STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DOLLAR GENERAL,	)	
	)	
Petitioner,	)	
	)	
vs.	)	
	)	Case No. 09-6877
DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION,	)	
	)	
Respondent,	)	
	)	
and	)	
	)	
HCA HEALTH SERVICES OF FLORIDA, INC., d/b/a OAK HILL HOSPITAL,	)	
	)	
Intervenor.	)	
	)	

RECOMMENDED ORDER

A final hearing was conducted in this case on March 24 and 25, 2010, in Tallahassee, Florida, before Barbara J. Staros, Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Cindy R. Galen, Esquire
Eraclides, Johns, Hall, Gelman
Johannssen & Goodman, LLP
2030 Bee Ridge Road
Sarasota, Florida 34239

For Respondent: Mari H. McCully, Esquire
Cynthia Jakeman, Esquire
Department of Financial Services
Division of Workers Compensation
200 East Gaines Street
Tallahassee, Florida 32399

For Intervenor: Richard M. Ellis, Esquire
Rutledge, Ecenia & Purnell, P.A.
119 South Monroe, Suite 202
Post Office Box 551
Tallahassee, Florida 32302

STATEMENT OF THE ISSUE

The issue is what is the correct amount of workers' compensation reimbursement to Oak Hill Hospital for emergency services rendered to patient J.M. for a work-related injury?

PRELIMINARY STATEMENT

On October 29, 2009, the Department of Financial Services, Division of Workers' Compensation (the Department) issued a Workers' Compensation Medical Services Reimbursement Dispute Determination (the Determination) pursuant to Section 440.13(7), Florida Statutes, finding that Dollar General (Dollar) must reimburse Oak Hill Hospital (Oak Hill) a total amount of $4,192.50 for services rendered to injured employee J.M. Petitioners Dollar and Qmedtrix Systems, Inc. (Qmedtrix) timely filed a Petition for Administrative Hearing challenging the Determination.

The Petition was transmitted to the Division of Administrative Hearings on or about December 18, 2009. Oak Hill filed a Petition to Intervene which was granted. A telephonic motion hearing was held on March 5, 2010. Following the hearing, the undersigned entered an Order on Pending Motions which denied the Department's Motion for Summary Recommended Order, granted Petitioners' Motion to Redact Public Information from Exhibits, and granted Petitioner's Motion to Amend. As a result, the style of the case was amended to reflect that Qmedtrix was no longer a party in this proceeding, and Dollar became the sole Petitioner. Oak Hill's Unopposed Motion for taking Official Recognition was granted.

The case proceeded to hearing as scheduled on March 24 and 25, 2010. Case numbers 09-6875 and 09-6876 were heard simultaneously with this case, but the three cases were not consolidated.

At hearing, Oak Hill presented the testimony of Allan W. March, M.D. Oak Hill offered Exhibits numbered 15 through 25, 27, and 28, which were admitted into evidence. The Department adopted Oak Hill's case-in-chief as its own. Petitioner presented the testimony of William von Sydow and David Perlman, M.D. Petitioner's Exhibits numbered 1, 5, 10, 11, 22, 23, and 25 through 28 were admitted in to evidence. Rulings were reserved on Petitioner's Exhibits 9 and 24. Upon consideration,

Petitioner's Exhibits 9 and 24 are rejected.[1/] Petitioner's Exhibit 7 was proffered.

A four-volume transcript was filed on April 12, 2010. The parties timely filed Proposed Recommended Orders which have been duly considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Petitioner, Dollar, is a carrier within the meaning of Subsections 440.02(4) and (38), Florida Statutes, and Florida Administrative Code Rule 69L-7.602(1)(w).

2. Respondent, the Department, is charged with the review and resolution of disputes regarding the payment of providers by carriers for medical services rendered to injured workers. The Department has exclusive jurisdiction to decide reimbursement disputes. § 440.13(7) and (11)(c), Fla. Stat.

3. Intervenor, Oak Hill, is a health care provider within the meaning of Subsections 440.13(1)(h) and (3)(f), Florida Statutes. Oak Hill is an acute care hospital located in Spring Hill, Hernando County, Florida.

4. On July 14, 2009, Oak Hill provided emergency services to the patient J.M., a 47-year-old male, who was injured at his place of work. J.M. was examined by Oak Hill's emergency department physician, was administered Hydromorphone, an opiate pain medication and was given an injection of pain medication. The emergency physician also ordered a computed Tomography (CT)

scan of the lower spine. The results of the CT was negative for fractures.

5. Oak Hill's total charges for J.M.’s outpatient emergency services were $5,590.00. Oak Hill submitted its claim for reimbursement using the standard “uniform billing” form, UB-04. The UB-04 sets out each service provided to J.M., the individual charge for each service, and the total charge. The individual services on the UB-04 submitted for patient J.M. are listed as follows: pharmacy; CT scan of the lower spine; the emergency department visit itself, and the pain medication.

6. Oak Hill’s claim was received by MCMC, an organization described as a “third-party administrator,” and was referred in turn to Qmedtrix. Qmedtrix is a medical bill-review agent located in Portland, Oregon. Qmedtrix performs bill review by referral from carriers and third-party administrators, and performed for Dollar a bill review of the bill submitted by Oak Hill. For its compensation, Qmedtrix is paid a percentage of the difference, if any, between the amount billed by the facility and the amount paid by the carrier.

7. Following Qmedtrix’ review, Oak Hill received a check from Dollar in the amount of $827.73, along with an “Explanation of Medical Benefits” review (EOBR), which is required to be sent along with the bill payment.

8. The EOBR sets out the four individual components of Oak Hill's claim. For the first component (the pharmacy charge), the EOBR indicates that "Reimbursement for the outpatient service is based on 75% [sic] the hospital's charges." The CT scan, with charges of $4,110.25, is paid at $247.00 with the explanation, "Payment in accordance with the Georgia Hospital Inpatient Fee Schedule." The emergency department visit references CPT code 99284, the same as appears on the UB-04, but is paid at $524.70 rather than at 75 percent of charges. That adjustment is explained as follows: "Reductions are due to charges exceeding amts reasonable for provider's demographic area. Please direct questions to Qmedtrix 800/833/1993." The last component of the claim, for the pain medication, is paid at $48.90 with the same explanation.

9. The EOBR has one column entitled "Reason Code." In completing an EOBR, insurers must select a code from a list of approximately 50 codes found in Florida Administrative Code Rule 69L-7.602(5)(o)2., which identifies the reason for the disallowance or adjustment. For the emergency room visit, the EOBR shows a code of 93, which is explained as follows: "Paid: No modification to the medical bill: Payment made pursuant to contractual arrangement."

10. As mentioned above, the EOBR indicates a "code" of 99284, the same code used on the UB-04 submitted by Oak Hill.

These codes are among five codes that are used by hospitals to bill emergency department visits based on “level” of intensity rendered. These codes are taken from the American Medical Association’s Current Procedural Terminology (or CPT), a coding system developed for physician billing, not for hospitals. Over the years, these CPT codes were adopted by hospitals for billing emergency department visits. Emergency department services are billed with CPT codes 99281 through 99285.

11. After receiving the payment and EOBR, Oak Hill timely filed a Petition for Resolution of Reimbursement Dispute, with attachments, to the Department. Oak Hill alleged in its Petition that the correct reimbursement amount owed was $4,192.50, leaving an underpayment of $3,364.77. However, subsequently, Oak Hill received a second check from Dollar, and an accompanying EOBR. The second check was for $2,835.69. The EOBR indicated that the second payment was for the CT scan of the lower spine. The sum of two payments for the CT scan is $3,082.69, which amounts to 75 percent of Oak Hill’s charges for the procedure. No further allowance was made for the other three components of Oak Hill’s claim.

12. Qmedtrix, acting as Dollar’s representative, then filed Dollar’s Response to Petition for Resolution of Reimbursement Dispute and attachments with the Department.

13. Attached to the Response was a letter from Mr. von Sydow dated October 19, 2009. The letter asserted that the correct payment to the hospital (Oak Hill) should be determined on an average of usual and customary charges for all providers in a given geographic area, rather than the hospital's usual and customary charges. As authority, Mr. von Sydow cites the case of One Beacon Insurance v. Agency for Health Care Administration, 958 So. 2d 1127 (Fla. 1st DCA 2007). The letter also requested that the Department "scrutinize the bill in question in order to determine, first, whether the hospital in fact charged its usual charge for the services provided and, second, whether the billed charges are in line with the customary charges of other facilities in the same community."

14. The letter further alleges that the hospital "upcoded" the emergency room visit, billing using CPT code 99284, asserting that the proper billing code should have been 99282. The letter concludes that the amount paid, $524.70, for the emergency department visit exceeds the amount "usual and customary" charges that Qmedtrix asserts, on behalf of Dollar, is applicable to the claim.

15. On October 29, 2009, the Department issued its Determination. The Determination states in pertinent part:

> Rule 69L-7.602(5)(q), F.A.C., stipulates the EOBR codes that must be utilized when explaining to the provider the carrier's

reasons for disallowance or adjustment. The carrier appended EOBR codes 92 or 93 to the billed items. For the line items appended with EOBR code 92, the reimbursement fails to equal the maximum reimbursement allowances (MRAs) provided in the 2006 HRM. Furthermore, the carrier failed to substantiate the existence of a reimbursement contract between Oak Hill and the carrier. Therefore, the reimbursement adjustments to line items appended with EOBR codes, 92 and 93, are unsubstantiated.

Moreover, the carrier appended to the billed line items three unique codes which indicate: "Reductions are due to charges exceeding amts reasonable for provider's demographic area"[sic], "Reimbursement for this outpatient service is based on 75% of the hospital's charges", and "Payment in accordance with the Georgia hospital inpatient payment fee schedule." These explanations fail to afford the petitioner any understanding for the reimbursement adjustments documented on the EOBR. Furthermore, the Florida Statutes and Rules do not support the carrier's reasoning for the reimbursement adjustments documented on the EOBR. Therefore, the carrier failed to substantiate its adjustment to reimbursement on the EOBR as required by Rule 69L-7.602, F.A.C.

Lastly, the 2006 HRM, Section 12.A., vests specific authority in the carrier to review the hospital's Charge Master to verify charges on the itemized statement and to disallow reimbursement for specifically itemized services that do not appear to be medically necessary. None of the submitted documentation indicates the carrier elected to exercise this option. Whereas, the carrier did not allege that any service was deemed not "medically necessary," or that the charges on the billing form failed to match the petitioner's Charge Master, the OMS finds the charges billed by the hospital

> are the hospital's usual and customary charges.
>
> The 2006 HRM provides for reimbursement of emergency room services at seventy-five percent (75%) of the hospital's usual and customary charges. Whereas, the carrier failed to substantiate is[sic] adjustments to reimbursement on the EOBR, the OMS determines correct and total reimbursement equals $4,192.50 ($5590.00x.75).

16. The determination letter also informed Dollar of its right to an administrative hearing. Dollar timely filed a Request for Administrative Hearing, which gave rise to this proceeding.

CODING FOR J.M.'S EMERGENCY SERVICES

17. As mentioned above, Oak Hill reported the emergency department visit using CPT Code 99284. No one from the hospital testified, but Oak Hill's expert, Allan W. March, M.D., reviewed Oak Hill's hospital record for J.M.

18. Dr. March is a graduate of Dartmouth College and Johns Hopkins University Medical School. He has extensive experience in, among other things, hospital physician practice and utilization review. Dr. March describes utilization as the oversight of medical care to affirm that it is appropriate, cost-effective, and medically necessary. Dr. March has worked as an emergency department physician and has personally treated upwards of 5,000 workers' compensation patients. Dr. March testified on behalf of Intervenor and Respondent.

19. Dr. March described J.M. from the hospital record as follows: “This patient is a 47-year-old man who immediately, just prior to presentation, fell off a ladder 7 feet above the ground and injured his back and presented with pain in the right lower back, with a swollen and tender area that was visible and palpable to the examining physician, with pain on movement of his lower back.” Dr. March reviewed Oak Hill’s hospital record for J.M. to analyze whether Oak Hill appropriately used CPT code 99284.

20. Oak Hill’s coding for the emergency department visit is based on the American College of Emergency Physicians’ “ED Facility Level Coding Guidelines” (ACEP Guidelines). Oak Hill’s medical record for J.M.’s care includes an “Emergency Department Charge Sheet” corresponding precisely to the ACEP Guidelines, and in which the abbreviation “CT” is circled in the section for CPT code 99284. By using the ACEP Guidelines, Oak Hill used a nationally recognized methodology in determining the level of service to which the hospital should bill.

21. Under the ACEP guidelines, the CPT code level assigned is always the highest level at which a minimum of one “possible intervention” is found. In this case, Dr. March determined that J.M. was given a CT scan. In Dr. March’s opinion, Oak Hill correctly assigned a 99284 code to J.M.’s emergency department

visit, and that assignment is substantiated by the medical record under the ACEP Guidelines.

22. Dr. March further explained that the coding level of a hospital does not correspond directly to the coding level assigned by the physician. The physician's services are coded under the CPT-4 coding book. According to Dr. March, the CPT coding manual is applicable to facility coding only if the hospital chooses to use this as a basis in their methodology for coding. Further, Dr. March explained that the separate billing of the emergency department visit captures separate and distinct costs incurred by hospitals that are not included in line-items for procedures.

23. The claim submitted by Oak Hill was sent to Qmedtrix for a bill review. Its data elements were first entered into Qmedtrix' proprietary bill-review software known as "BillChek." The software placed Oak Hill's claim on hold for manual review. The claim was then manually reviewed by William von Sydow, Director of National Dispute Resolution for Qmedtrix.

24. Although his educational background is in law, Mr. von Sydow is a certified coder certified by the American Health Information Management Association (AHIMA). Mr. von Sydow determined in his bill review that Oak Hill should have used code 99282 instead of 99284, although payment was based on

code 99283 at 75 percent of what he calculated to be the average charge in the community for 99283.

25. Mr. von Sydow described what he considers to be inconsistencies between certain diagnosis codes under the International Classification of Diseases, Ninth Edition (ICD-9) and the CPT codes used to classify the emergency department visit. He considers the ICD-9 codes on Oak Hill's claim to be inconsistent with CPT code 99284. In his view, the ICD-9 codes correspond more closely with CPT code 99282. Moreover, Mr. von Sydow referenced a study by American Hospital Association (AHA) and AHIMA, which suggests that hospitals should count the number and kind of interventions to approximate the CPT factors, but that a hospital should not include in this count interventions or procedures, such as CTs or -rays, which the hospital bills separately. He further acknowledged that the federal Centers for Medicare and Medicaid Services (CMS) allow hospitals to use their own methodology in applying the CPT codes.

26. David Perlman, M.D., received his undergraduate degree from Brown University and his medical degree from the University of Oregon. He has considerable experience as an emergency room physician. For the past six years, he has worked for Qmedtrix initially doing utilization review and as their medical director since 2005. Dr. Perlman testified on behalf of Dollar.

27. Dr. Perlman is also familiar with the ACEP guidelines relied upon by Dr. March and the AHA/AHIMA study relied upon by Mr. von Sydow. He is also familiar with the CPT code handbook. Dr. Perlman suggested that the use of the ACEP guidelines could result in reimbursement essentially already provided in a separate line-item. He agrees with the methodology recommended by the AMA/AHIMA study. That is, counting the number and kind of interventions or procedures to approximate the CPT book's factors to consider in selecting the code billed for emergency department services, but not including in this count interventions or procedures, such as CTs or X-rays, which the hospital bills separately.

28. In Dr. Perlman's opinion, J.M.'s injuries supported assignment of CPT code 99283 rather than 99284. The fact that J.M. underwent a CT scan did not alter this conclusion. According to Dr. Perlman, use of a CT scan in a patient's emergency department treatment determines that the facility may assign a 99284 code under the ACEP guidelines. In his opinion, this does not necessarily reflect the severity of the illness or injury.

29. Dr. Perlman acknowledged, however, that hospitals are free to use the ACEP guidelines and that many hospitals do so.

30. The preponderance of the evidence establishes that there is no national, standardized methodology for the manner in which hospitals are to apply CPT codes 99281-99285 for facility billing. The preponderance also establishes that, while there is a difference of opinion as to whether ACEP guidelines are the best method, it is a nationally recognized method used by many hospitals. Oak Hill's use of this methodology is supported by the weight of the evidence as appropriate. J.M.'s hospital record amply documents the interventions required for the assignment of CPT code 99284 under the ACEP guidelines. Therefore, coding J.M.'s emergency department visit as 99284 by Oak Hill was appropriate.

31. There is no dispute that Oak Hill's charges as represented on the UB-04 form conform to its internal charge master, or that the services represented were in fact provided, or that they were medically necessary.

CONCLUSIONS OF LAW

32. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this case pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2009).

33. This proceeding, like all other proceedings conducted under Section 120.57(1), Florida Statutes, is de novo in nature. See § 120.57(1)(k), Fla. Stat.

34. Generally, unless there is a statute which provides otherwise, the party asserting the affirmative of an issue has the burden of proof. See Department of Transportation v. J.W.C. Co., Inc., 396 So. 2d 778, (Fla. 1st DCA 778 at 788; Balino v. Dept. of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). It was Oak Hill which petitioned the Department for affirmative relief and agency action, i.e., a determination that the Petitioner improperly disallowed payment. See § 440.13(7)(a), (c). Accordingly, Oak Hill, as the health care provider who is asserting entitlement to reimbursement for medical services provided to J.M., has the burden of proving that the charges for the services provided do not constitute over-utilization.

35. The standard of proof is a preponderance of the evidence. See § 120.57(1)(j), Fla. Stat.

36. This case involves a reimbursement dispute under Section 440.13(7), Florida Statutes (2009). Section 440.13, Florida Statutes, reads in pertinent part:

> (6) UTILIZATION REVIEW--Carriers shall review all bills, invoices, and other claims for payment submitted by health care providers in order to identify overutilization and billing errors, including compliance with practice parameters and protocols of treatment . . . If a carrier finds that overutilization of medical services or a billing error has occurred, or there is a violation of the practice parameters and protocols of

treatment established in accordance with this chapter, it must disallow or adjust payment for such services or error without order of a judge of compensation claims or the department, if the carrier, in making its determination, has complied with this section and rules adopted by the agency.

(7) UTILIZATION AND REIMBURSEMENT DISPUTES--

(a) Any health care provider . . . who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 30 days after receipt of notice of disallowance or adjustment of payment, petition the agency to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the agency results in dismissal of the petition.

(b) The carrier must submit to the department within 10 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit the requested documentation to the agency within 10 days constitutes a waiver of all objections to the petition.

(c) Within 60 days after receipt of all documentation, the department must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

> (d) If the department finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection.
>
> (e) The department shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.
>
> * * *
>
> (11) AUDITS.--
>
> (c) The department has exclusive jurisdiction to decide any matters concerning reimbursement, to resolve any overutilization dispute under subsection (7). . .
>
> * * *
>
> (12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.--
> (a) A three member panel is created. . . [which] shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance by physicians, hospitals,. . . <u>All compensable charges for hospital outpatient care shall be at 75 percent of usual and customary charges</u>, except as otherwise provided by this subsection.. . . (emphasis supplied)

37. Thus, Subsection (6) requires carriers to review all bills for payment submitted by health care providers for errors. Subsection (7) sets forth the procedure for resolving disputes concerning payments for services rendered to injured workers.

38. Pursuant to Subsection 440.13(7)(e), Florida Statutes, the Department has adopted Florida Administrative Code Rule 69L-7.501, which incorporates by reference the Reimbursement Manual for Hospitals, 2006 Edition (the manual), which provides in pertinent part:

> Section X: Outpatient Reimbursement
>
> A. Reimbursement Amount.
>
> Except as otherwise provided in this Section, hospital charges for services and supplies provided on an outpatient basis shall be reimbursed at seventy-five percent (75%) of usual and customary charges for medically necessary services and supplies, and shall be subject to verification and adjustment in accordance with Sections XI and XII of this Manual.[2/]

39. At issue in this proceeding is whether reimbursement to Oak Hill should be based upon the individual hospital's usual charge or should instead be based upon the usual and customary charge of all hospitals within the same geographic area. Relying primarily on One Beacon Insurance v. Agency for Health Care Administration, 958 So. 2d 1127 (Fla. 1st DCA 2007), Petitioner argues that reimbursement should be based upon the usual and customary charge in the community. The Petition for Administrative Hearing argues that Florida Administrative Code Rule 69L-7.501, and its interpretation by the Department, is contrary to the provisions of Section 440.13(12), Florida Statutes.

40. The Department has consistently applied the 2006 Manual to refer to the individual hospital's "usual and customary charges." (See cases officially recognized referenced in and attached to Oak Hill's Unopposed Motion for Taking Official Recognition.)

41. Until determined otherwise in a Section 120.56, Florida Statutes, rule challenge proceeding, Florida Administrative Code Rule 69L-7.501 is presumptively valid. Any determination that a duly promulgated rule is contrary to a statute is beyond the authority of the undersigned and is within the purview of an appellate court. See Clemons v. State Risk Management Trust Fund, 870 So. 2d 881, 884 (Fla. 1st DCA 2004) (Benton, J., concurring). Accord, Amerisure Mutual Insurance Company v. Agency for Health Care Administration, DOAH Case No. 07-1755 (Order relinquishing Jurisdiction and Closing File, January 23, 2008) (Quattlebaum, A.L.J.); FFVA Mutual v. Agency for Health Care Administration, DOAH Case No. 07-5414 (Order, March 26, 2008) (Wetherell, A.L.J.).

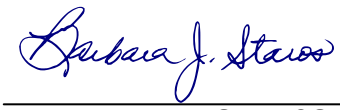
RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED:

That the Department of Financial Services, Division of Workers' Compensation, enter a Final Order requiring Petitioner to remit payment to Oak Hill consistent with the Determination Letter dated October 29, 2009, and Section 440.13(7), Florida Statutes.

DONE AND ENTERED this 17th day of June, 2010, in Tallahassee, Leon County, Florida.



BARBARA J. STAROS
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 17th day of June, 2010.

ENDNOTES

1/ As to Exhibit 9, Respondent/Intervenors' relevancy objections are sustained. The witness testified that he did not rely on these documents to form his opinion. Regarding Exhibit 24, Respondent/Intervenor argue that Section 90.956 was not complied with in that Petitioner did not comply with the requirement of Section 90.956, Florida Statutes, in that the originals or duplicates of the data from which the summary is compiled was not made available; and that it is impractical and may be impossible to make available the thousands of individual hospital claims that underlie the summaries sought to be admitted. Petitioner argues that it offered to make available

the “underlying data” in so far as the data is part of several sources of data for which the amount paid is based. However, what Dollar cannot do is make available the actual data used by AHD in its summaries. Allowing access to Qmedtrix’ data and providing links to other data sources does not equate to providing access to the underlying data used by AHD in compiling the summaries sought to be introduced by Dollar. No one from AHD, the entity which compiled the data submitted by various hospitals to the federal government, testified. No one from the reporting hospitals testified. Mr. von Sydow’s testimony cannot be used as a conduit for impermissible hearsay statements to be admitted as evidence. Gerber v. Iyengar, 725 So. 2d 1181 (Fla. 3rd DCA 1998). Further, this data is uncorroborated and, therefore, is not sufficient in itself to support a finding of fact as contemplated by Section 120.57(1)(c), Florida Statutes.

Whether Mr. von Sydow can rely on these facts in forming his opinion is another matter. Petitioner argues that even if the data is inadmissible, Mr. von Sydow may rely on this data to form his opinion, citing Section 90.704, Florida Statutes. Upon review of the record, the undersigned finds that the data are of a type reasonably relied upon by experts in the subject in forming their opinions. Accordingly, Respondent/Intervenor’s motion to strike Mr. von Sydow’s testimony in this regard is denied.

2/ The “verification and adjustment in accordance with Sections XI and XII” of the Manual is not applicable in this case.

COPIES FURNISHED:

Cindy R. Galen, Esquire
Eraclides, Johns, Hall, Gelman
Johannssen & Goodman, LLP
2030 Bee Ridge Road
Sarasota, Florida 34239

Mari H. McCully, Esquire
Cynthia Jakeman, Esquire
Department of Financial Services
Division of Workers’ Compensation
200 East Gaines Street
Tallahassee, Florida 32399

Richard M. Ellis, Esquire
Rutledge, Ecenia & Purnell, P.A.
119 South Monroe Street, Suite 202
Post Office Box 551
Tallahassee, Florida 32301

Julie Jones, CP, FRP, Agency Clerk
Department of Financial Services
Division of Legal Services
200 East Gaines Street
Tallahassee, Florida 32399

Benjamin Diamond, General Counsel
Department of Financial Services
The Capitol, Plaza Level 11
Tallahassee, Florida 32399

Honorable Alex Sink
Chief Financial Officer
Department of Financial Services
The Capitol, Plaza Level 11
Tallahassee, Florida 32399

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.