STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MEGHAN HOTCHKISS, Petitioner, vs. DEPARTMENT OF MANAGEMENT SERVICES, DIVISION OF STATE GROUP INSURANCE, Respondent.	)	Case No. 12-0535

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on April 9, 2012, by video teleconference at sites in Tallahassee, Florida and Jacksonville, Florida, before E. Gary Early, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Brian J. Lee, Esquire
644 Cesery Boulevard, Suite 250
Jacksonville, Florida 32211

For Respondent: Sonja P. Mathews, Esquire
Department of Management Services
4050 Esplanade Way, Suite 160
Tallahassee, Florida 32399-0950

STATEMENT OF THE ISSUE

The issue is whether Respondent properly denied payment of certain charges related to out-of-network surgical procedures

pursuant to the State Employees' PPO Group Health Insurance Plan.

PRELIMINARY STATEMENT

By letter dated June 16, 2010, Respondent, Department of Management Services, Division of State Group Insurance (Respondent or DSGI), notified Petitioner, Meghan Hotchkiss (Petitioner), that it intended to deny her Level II Appeal, by which Petitioner challenged the decision of Blue Cross & Blue Shield of Florida (BCBSF), to pay $1,526.57 of a total of $29,976.00 in surgery-related charges from Dr. Mark Piper, a non-network provider. Petitioner received the notice on July 2, 2010.

On July 23, 2010, Petitioner filed a Petition to Request a Hearing (Formal Hearing). Petitioner alleged that "BCBSF inappropriately classified the surgery that I underwent, in violation of its plan documents, as some other kind of procedure than the one I had, which had a much lower allowance."

On February 9, 2012, Respondent referred the Petition to the Division of Administrative Hearings. The record is silent as to the reason for the passage of more than 1 1/2 years from the date of filing of the Petition to the date of transmittal, but there has been no objection by Petitioner.

The final hearing was scheduled for April 9, 2012, and was held as scheduled. At the final hearing, Petitioner testified

on her own behalf. Petitioner's Exhibits 1(a)-(c) and 4-6 were received into evidence. Respondent presented the testimony of Kathy Flippo, a registered nurse and Respondent's Legal Nurse Specialist; Kevin Tincher, BCBSF's Senior Manager of Coding and Professional Payment; Colleen McArdle, BCBSF's Manager of Pre-service Medical Review; and Jessica Bonin, BCBSF's Critical Inquiry Analyst. Respondent's Exhibits 2, 6, and 7 were received into evidence.

By agreement of the parties, the record was held open to allow for the filing of deposition testimony to be considered in lieu of live testimony. On August 7, 2012, prior to the closing of the record, the parties each filed the deposition transcript of Dr. Scott Imray, a consulting expert witness retained by Respondent. Since both parties filed the deposition transcript prior to the closing of the record, indicating their mutual -- though independently expressed -- desire to have it be considered by the undersigned, the deposition transcript and its exhibits are accepted and admitted in evidence as Joint Exhibit 1.

Dr. Imray was proffered by Respondent as an expert in the area of oral and maxillofacial surgery. Counsel for Petitioner had no questions regarding Dr. Imray's qualifications, and no objection to the proffer has been made. Based on Dr. Imray's qualifications as set forth in his curriculum vitae and his

testimony, he is accepted as proffered. The deposition transcript will be considered as though the witness testified in person.

The final hearing was not transcribed. The date for filing post-hearing submittals was set for August 17, 2012. Respondent timely filed its Proposed Recommended Order, which has been considered in the preparation of this Recommended Order. In its Proposed Recommended Order, Respondent included three appendices. Appendix A consisted of a document that was not entered in evidence at the final hearing or by agreement of the parties prior to the closing of the record. Appendices B and C consist of duplicates of documents introduced as parts of Petitioner's Exhibits 1(a) and 1(c), respectively. Those documents are not admitted as evidence, and are not part of the evidentiary record of this proceeding. Petitioner filed her Proposed Recommended Order on August 21, 2012. Although filed late, the undersigned finds no prejudice would result from consideration of Petitioner's Proposed Recommended Order, and it has therefore been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times pertinent to this proceeding, Petitioner, who is now 29 years old, was an employee of the University of West Florida, and was enrolled as a member of the State

Employees PPO Plan (Plan). She started employment with the University on December 1, 2007, and became enrolled in the Plan. Respondent was provided with the State Employees' PPO Plan Group Health Insurance Plan Booklet and Benefits Document, effective January 1, 2007 (Plan Booklet).

2. The Department of Management Services is responsible for all aspects of the purchase of health care for state employees, including those services provided under the Plan. Respondent is responsible for the administration of the state group insurance program.

3. As authorized by law, Respondent has contracted with Blue Cross & Blue Shield of Florida (now known as Florida Blue) as its third-party medical claim administrator of employee health insurance benefits.

4. The Plan Booklet contains the terms and conditions of the state group insurance program applicable to this proceeding. The booklet provides, as part of its Summary of Benefits, that:

> When you go to non-network providers, this Plan pays benefits based on the non-network allowance. If your provider charges more than the non-network allowance, you are responsible for any amounts above the non-network allowance. In addition, because the Plan pays a lower benefit level for non-network care, you pay more out-of-pocket for non-network care.
>
> In selecting BCBSF as the Medical Claim Administrator for the state Employees' PPO Plan, DSGI agreed to accept the non-network

allowance schedule used by BCBSF to make payment for specific healthcare services submitted by non-network providers.

Keep in mind that you will receive benefits at the non-network level whenever you use non-network providers, even if a network provider is unavailable. (Emphasis added).

5. The booklet provides, in section 6, entitled About the Provider Network, that:

> In an effort to contain healthcare costs and keep premiums down, BCBSF has negotiated with PPC[SM] network healthcare providers to provide services to health Plan participants at reduced amounts. PPC[SM] network providers have agreed to accept as payment a set amount for covered services . . . .
>
> Non-network providers will bill you their regular charges. You will be responsible for a larger coinsurance and/or copayment, and you will be responsible for paying the difference between the provider's charges and the amount established as the non-network allowance for the service. The non-network allowance may be considerably less than the amount the non-network provider charges.
>
> * * *
>
> **An Important Note About Using Non-Network Providers**
>
> To make sure you receive the highest level of benefits from the Plan, it's important to understand when non-network benefits are paid. When you use non-network providers, you receive non-network benefits. Here are some examples.
>
> 1. In some situations, your network provider may use, or recommend that you receive care from, a non-network provider.

> For example, your network family doctor says you need to see another doctor and recommends a non-network doctor. It is your choice; you decide whether to go to the recommended non-network doctor or to ask your doctor for another recommendation to a network doctor. In this example, even though your family doctor is a network doctor, you will receive non-network benefits if you go to the recommended non-network doctor.
>
> 2. Sometimes the health care professional you need to see is not in the network. You receive non-network benefits when you use non-network providers, even if no network provider is available.

6. From an early age, Petitioner was plagued with symptoms of temporomandibular joint (TMJ) disorder. When she was seven or eight years old, Petitioner began to experience clicking in her jaw, and her jaw would occasionally lock. The symptoms soon abated.

7. While she was in sixth grade, Petitioner was fitted for orthodontic braces. The braces were removed when she was 12 or 13 years old.

8. When Petitioner was in her early teens, the clicking in her jaw reappeared. The clicking was now accompanied by pain in her jaw muscles, which was likened to that experienced from a migraine headache.

9. Petitioner was referred to an oral surgeon regarding her jaw symptoms. The surgeon recommended a course of physical therapy for her jaw, and placed her on a diet that eliminated

foods that were "chewy." Despite those measures, Petitioner's jaw began to periodically lock open.

10. At the age of 16, Petitioner had her wisdom teeth removed. While that procedure resulted in a cessation of the locking, Petitioner could only open her mouth about one-quarter of the way. She was also prescribed Tylenol #3, which contained codeine, for pain.

11. At the age of 16 or 17, Petitioner was given splints to keep her jaw in alignment. Petitioner was clenching her teeth so hard in response to the pain, that she broke several splints during the first year that she had them.

12. By the time she was 19 years old, Petitioner's headaches were "out of control." She was referred to the facial pain center at the University of Florida, where she was fitted with custom-made splints. She was provided with a course of physical therapy, and was prescribed muscle relaxers. When she returned home from college for the summer, she did the recommended physical therapy, which was effective in relieving her symptoms for a few months.

13. Petitioner was subsequently referred to Dr. Widmer, a physician at the University of Florida. Dr. Widmer performed an arthrocentesis, by which a steroid solution was injected into Petitioner's temporomandibular joints. The procedure was ineffective.

14. By 2006, when Petitioner was 23 years old, the opening of her mouth began to be accompanied by a "squishing" noise. Dr. Widmer referred Petitioner to Dr. Margaret Dennis.

15. Dr. Dennis ordered an MRI of Petitioner's jaw to determine if there was any bone damage. The MRI revealed that the bones of the temporomandibular joint were degraded, and that the disk material was calcified. Dr. Dennis increased the dosage of Petitioner's pain medications to handle the pain associated with her condition.

16. After a period of time, and with Petitioner having little relief from her symptoms, Dr. Dennis referred her to Dr. Mark Piper, a physician who is board-certified in oral and maxillo-facial surgery. Dr. Piper maintains his office in Tampa, Florida.

17. Petitioner had her first appointment with Dr. Piper in August 2009.

18. Dr. Piper ordered a level 3 MRI, which produced a clearer picture than her earlier MRI, as well as a CAT scan. He took imprints of Petitioner's teeth, and performed a physical examination of the bones of Petitioner's jaw. The results of the imaging and the physical exam showed severe and active degeneration of Petitioner's temporomandibular joints, especially the right joint.

19. To remedy Petitioner's physical condition, Dr. Piper recommended a bilateral arthroplasty of Petitioner's jaw, consisting of a fat graft to the right temporomandibular joint, and a procedure involving the disk tissue to the left temporomandibular joint. Given the exhaustion of more conservative forms of treatment, arthroplasty was, by this point, appropriate and medically necessary for the resolution of Petitioner's condition.

20. On August 25, 2009, Dr. Piper provided Petitioner with a statement summarizing his diagnosis, and providing an explanation of his recommended course of action.

21. Petitioner provided Dr. Piper's statement to BCBSF to explain the necessity for her proposed out-of-network treatment. The evidence suggests that Petitioner provided the CPT codes for the recommended procedures at issue.

22. CPT codes are a system by which medical services are assigned numbers to describe those services, and are used by insurers to establish a uniform schedule of reimbursement. On a case-by-case basis, the numbers are provided by medical service providers to describe the services they have rendered.

23. Respondent maintains a business record of all communications between it and its customers. On August 27, 2009, those records reflect that a telephonic request for information was received either from or regarding Petitioner.

The notation regarding the request for information stated, in pertinent part:

> PRICING FOR PROC CODES 21240 AND 69990 RELATED TO TREATMENT OF TMJ NEEDED, PROV IS 62468....ALLOWANCES ARE 1168.09 AND 252.53

24. Petitioner acknowledged that she received the information regarding the rates, but understood the rates to be estimated amounts, and not official because the person with whom she spoke could not give final figures over the telephone.

25. Later on August 27, 2009, Respondent's records reflect that a second telephonic request for information was received either from or regarding Petitioner. The notation regarding the request for information stated, in pertinent part:

> MEMBER S REQUESTING TO SPK WITH THE VPCR [Voluntary Pre-coverage Review] AREA AS SHE WANTS PRIOR APPROVAL OF CODES 21240 AND 69990 FOR THE TREATMENT OF TMJ....I ADVISED HER OF THE PROCESS AND TO GO AHEAD AND SUBMIT THE LMN [Letter of Medical Necessity] AND SUPPORTING DOCS IF THE NON PAR PROV IS UNWILLING TO CALL OUR OFFICE..I EXPLAINED THAT THE DET WOULD BE MADE AND IF ADDTLS DOCS ARE REQD, THIS WOULD BE ADVISED ALSO, ADV MEMBER SHE CAN WITH FAX OR MAIL TO AD ON THE BACK OF INS CARD.

26. Respondent's records reflect no further telephonic inquiries regarding Petitioner until October 19, 2009.

27. Petitioner scheduled her surgery with Dr. Piper for September 16, 2009.

28. Petitioner testified that approximately one week prior to the scheduled surgery, BCBSF sent an e-mail to Petitioner providing her with the name of a network provider in Jacksonville who could perform the surgery necessary to resolve her TMJ issues. She further testified that she contacted the network provider's office, and was advised by a Dr. Milton that the medical group could not perform the surgery. Petitioner testified that she advised BCBSF of that information, and advised BCBSF that there was no one in-network that could perform the surgery. A copy of the e-mail was not provided, nor was there evidence to otherwise corroborate the described events. Therefore, no finding can be made as to that alleged series of communications.

29. Respondent maintains a list of network health care providers by specialty type and location. The list is available on-line. The list includes a number of oral and maxillofacial surgeons located in the Jacksonville area. However, one cannot determine from the list whether a provider is capable of performing a particular procedure under the specialty.

30. The evidence demonstrates that Dr. Piper is an accomplished oral and maxillofacial surgeon, with particular expertise in disc removal and fat graft placement surgery for the temporomandibular joint. However, even if Dr. Piper is the surgeon most qualified to perform the procedure, that does not

mean he is the surgeon singularly qualified to perform the procedure.

31. Dr. Imray testified that he has referred patients for bilateral arthroplastic procedures on many occasions. His referrals were generally to oral and maxillofacial surgeons practicing at teaching centers in Jacksonville and Gainesville. Although he could not testify whether such surgeons were in the State Employees' PPO network without consulting his PPO reference book, he could recall no instance of having had to refer a patient to an out-of-network provider, "because most of the teaching centers take most of the plans."

32. The evidence in this case failed to demonstrate that there were no network providers capable of performing the procedures medically necessary for the resolution of Petitioner's TMJ issues.

33. Having concluded that Dr. Piper afforded her with the greatest likelihood for a successful outcome, Petitioner proceeded with the surgery as scheduled. After a recovery period of two years, which included braces to adjust her teeth to fit her repaired and aligned temporomandibular joints, the surgery has proven to be a complete success. Petitioner testified convincingly that the surgery was a life-changing event.

34. The total cost to Petitioner for the surgical and immediate post-operative procedures was $30,005.00.

35. In November, 2009, Petitioner began the process of filing her claim with BCBSF. After some difficulties, the submission of the claim was completed in January, 2010. The amount billed to BCBSF was $29,976.00. The bulk of the charge, in the amount of $24,650.00, was for the procedure identified by Dr. Piper as CPT Code 21240. The documentation submitted clearly indicated -- both by the description of the CPT Code 21240 procedure as "Bilateral TMJ Arthroplasty" and by the listing of the modifier code "50", which was the code assigned for procedures that were bilateral -- that the arthroplasty procedure was bilateral.

36. On March 11, 2010, BCBSF notified Petitioner that it would reimburse her medical expenses related to the surgery in the amount of $1,526.57. That amount included $1,168.09 for the arthroplasty (CPT Code 21240), and $358.48 for the surgical splint (CPT Code 21085). BCBSF indicated that it would not pay the $1,650.00 charge for the operating microscope (CPT Code 69990) on the basis that the charge was incidental to the primary arthroplasty procedure, and therefore included in the $1,168.09 allowance for that procedure. BCBSF also denied payment for a ZZ Therabite (CPT Code 99070).

37. The reimbursement amount was calculated by applying the CPT Codes provided by Dr. Piper to the BCBSF fee schedule. The amount was then further adjusted by the non-network payment allowance to reach the final reimbursable amount. The process is mechanical, and involves no exercise of discretion. In that regard, the reimbursement for the arthroplasty was identical to the estimate provided to Petitioner on August 27, 2009.

38. The evidence demonstrates that the amounts paid to Petitioner for CPT Code 21240 procedures and the CPT Code 21085 surgical splint were accurately derived through application of the BCBSF fee schedule allowance to the procedure codes provided by Dr. Piper. However, as to the arthroplasty procedure, the evidence further demonstrates that the amount paid was based on a single procedure.

39. The arthroplasty performed by Dr. Piper was a bilateral procedure, which was clearly disclosed on the claim form. According to Kevin Tincher, BCBSF's senior manager of coding and professional payment, Petitioner is entitled to reimbursement for both procedures, with the reason given for not paying for both being Dr. Piper's failure to bill each part of the bilateral procedure on separate lines of the claim form. Given the lack of any instruction requiring that the two sides of a single bilateral procedure be billed on separate lines, especially given the application of the modifier code "50" to

indicate a bilateral procedure, the information provided on the claim form was neither deficient nor in error.

40. When two procedures of the same type are performed on the same day, the BCBSF fee schedule calls for reimbursement for the second procedure at a rate of 50 percent of the allowance for the first procedure. Under that schedule, Petitioner should have been reimbursed an additional $584.05, i.e., 50 percent of the $1,168.09 allowance for the first CPT Code 21240 procedure.

41. The evidence demonstrates that the Therabite device (CPT Code 99070) was "appropriate and acceptable" in Petitioner's case. Thus, the device was medically necessary under the circumstances. Petitioner should have been reimbursed, at the non-network rate, for that device.

42. During the hearing, Jessica Bonin, BCBSF's Critical Inquiry Analyst, admitted that the post-operative CT scan -- CPT Code 70486 -- in the amount of $301.93, should have been paid, but that the claim had not been reprocessed by BCBSF. Respondent further admitted in its Proposed Recommended Order that payment in the amount of $301.93 should be made for the post-operative CT scan. It is so found.

43. Petitioner initiated a Level I appeal with BCBSF. She provided BCBSF with as much of her medical history as she could locate, a list of medications, and all of the records, photographs, and X-rays that she could access. She also

provided a letter from Dr. Piper, dated March 18, 2010, in which he detailed the services provided to Petitioner. Dr. Piper's description suggests that the services provided to Petitioner were extensive, but did not suggest that the procedure itself varied from the procedure described in CPT Code 21240. However, Dr. Piper did reaffirm that the surgery was a bilateral procedure involving both of Petitioner's temporomandibular joints.

44. BCBSF did not change its decision as a result of the Level I Appeal.

45. On May 14, 2010, Petitioner filed a Level II Appeal with Respondent. On June 16, 2010, the Level II Appeal was denied.

CONCLUSIONS OF LAW

46. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes (2011).

47. Respondent is the agency charged by the legislature with the duty to oversee the administration of the State Group Insurance Program, including the group disability insurance program.

48. Petitioner, as the party asserting the right to payment of medical expenses under the State Employees' PPO Plan,

has the burden of proving by a preponderance of the evidence that her medical expenses qualified for coverage under the program. If she is able to do so, the burden shifts to Respondent to prove that the expenses were not covered due to the application of a policy exclusion. Herrera v. C.A. Seguros Catatumbo, 844 So. 26 664, 668 (Fla. 3d DCA 2003); State Comprehensive Health Ass'n v. Carmichael, 706 So. 2d 319, 320 (Fla. 4th DCA 1997).

49. Insurance contracts are to be construed in accordance with the plain language of the policy, with any ambiguity construed against the insurer, and in favor of coverage. U.S. Fire Ins. Co. v. J.S.U.B., Inc., 979 So. 2d 871, 877 (Fla. 2007); Kohl v. Blue Cross & Blue Shield of Fla., Inc., 988 So.2d 654, 658 (Fla. 4th DCA 2008). However, provisions of a contract of insurance that are clear and unambiguous, including those that constitute exclusions from coverage, should be enforced according to its terms. Bonich v. State Farm Mutual Automobile Insurance Company, 996 So. 2d 942, 943 (Fla. 2d DCA 2008).

50. Section 110.123, entitled State Group Insurance Plan, describes the powers and duties conferred on Respondent, in pertinent part, as follows:

> (5) DEPARTMENT POWERS AND DUTIES. — The department is responsible for the administration of the state group insurance program. The department shall initiate and supervise the program as established by this

> section and shall adopt such rules as are necessary to perform its responsibilities. To implement this program, the department shall, with prior approval by the Legislature:
>
> (a) Determine the benefits to be provided and the contributions to be required for the state group insurance program. Such determinations, whether for a contracted plan or a self-insurance plan pursuant to paragraph (c), do not constitute rules within the meaning of s. 120.52 or final orders within the meaning of s. 120.52. Any physician's fee schedule used in the health and accident plan shall not be available for inspection or copying by medical providers or other persons not involved in the administration of the program. . . .
>
> * * *
>
> Final decisions concerning . . . covered benefits under the state group insurance program shall not be delegated or deemed to have been delegated by the department.

51. The evidence demonstrates that Petitioner's medical expenses qualified for coverage under the Plan. Thus, Petitioner met her initial burden of proof.

52. Petitioner failed to prove the essential allegation of her Petition, i.e., that "BCBSF inappropriately classified the surgery that I underwent, in violation of its plan documents, as some other kind of procedure than the one I had, which had a much lower allowance." Rather, the evidence clearly demonstrates that Dr. Piper performed services consistent with those described in CPT Code 21240 and CPT Code 21085 and that

Respondent reimbursed Petitioner consistent with the fee schedule for those procedure codes.

53. Though not technically in the nature of an exclusion from coverage, the burden of proving that the reimbursement paid to Petitioner for her qualified medical expenses was the correct amount under the terms of the Plan lies with Respondent.

54. Respondent has proven, by a preponderance of the evidence, that the decision by BCBSF, as Respondent's contacted third-party administrator, to reimburse Petitioner for CPT Code 21240 services by a non-network provider in the amount of $1,168.09, to reimburse Petitioner for CPT Code 21085 services by a non-network provider in the amount of $358.48, and to deny reimbursement of CPT Code 69990 services on the basis that the charge was incidental to the primary procedure, was a correct application of the benefits and fee schedule under the Plan.

55. The evidence supports a conclusion that BCBSF failed to properly reimburse Petitioner for the full bilateral procedure, and for the post-operative CT scan in the amount of $584.05 and $301.93, respectively.

56. The evidence also supports a conclusion that BCBSF failed to properly reimburse Petitioner for the ZZ Therabite, which was a medically appropriate and necessary device. Payment for that device should be at the non-network rate.

RECOMMENDATION

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

RECOMMENDED:

That the Department of Management Services enter a final order finding that Petitioner is entitled to additional reimbursement for her medical expenses as set forth herein.[1/]

DONE AND ENTERED this 23rd day of August, 2012, in Tallahassee, Leon County, Florida.

E. GARY EARLY
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 23rd day of August, 2012.

ENDNOTE

[1/] In her Proposed Recommended Order, Petitioner suggests that the undersigned should award attorney's fees under section 120.595. No motion for fees has been filed as required for such a determination pursuant to section 120.595(2). Thus, no ruling as to the basis for such an award is made herein.

COPIES FURNISHED:

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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.