STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

FFVA MUTUAL INSURANCE COMPANY,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 12-2499
	)	
DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION,	)	
	)	
Respondent.	)	
	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on September 26, 2012, via video teleconference with sites in Orlando and Tallahassee, Florida. The parties appeared before Administrative Law Judge Lynne A. Quimby-Pennock of the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Julie Lewis Hauf, Esquire
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For Respondent: Mari H. McCully, Esquire
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STATEMENT OF THE ISSUE

The issue is whether FFVA Mutual Insurance Company (FFVA) should be required to pay an additional $4,169.00 (for a total of $13,155.60) to a health care provider for a pre-authorized scheduled outpatient surgery.

PRELIMINARY STATEMENT

On April 24, 2012, the Department of Financial Services, Division of Workers' Compensation, Office of Medical Services (Department), issued a Workers' Compensation Medical Services Reimbursement Dispute Determination directing FFVA to pay Summerlin Bend Surgery Center (Summerlin)[1/] reimbursement of $13,155.60 for services provided to Patient R.R. (the Patient). FFVA, having previously determined that $8,985.60 was the appropriate payment for the claim, filed a Petition for Formal Administrative Hearing (Petition) to challenge the Department's determination. On July 19, the Department forwarded the Petition to DOAH, which scheduled and conducted the proceeding.

Joint Exhibits A through I[2/] were admitted into evidence. FFVA presented one witness, Julie Dunn. FFVA's Exhibit 1 was admitted into evidence over objection. The Department presented the testimony of Arlene Cotton. The Department did not submit any additional exhibits.

On October 5, 2012, Petitioner's counsel[3/] filed a "Notice of Filing Designated E-mail Address Pursuant to Rule 2.516, Fla.R.Jud.Admin," designating a particular e-mail for service.

The one-volume Transcript was filed on October 16, 2012. The parties were advised that their proposed recommended orders (PROs) were due ten days from the filing of the Transcript. Both parties timely submitted their PROs, and each has been considered in the preparation of this Recommended Order.

Prior to the hearing, the parties filed a Joint Pre-hearing Stipulation containing a statement of admitted facts that have been reviewed and are incorporated herein as necessary.

FINDINGS OF FACT

1. FFVA, an insurance company, is a "carrier" as defined in section 440.13(1)(c), Florida Statutes (2012).[4/]

2. Summerlin is a health care provider as defined in section 440.13(1)(h) and is located in Fort Myers, Florida.

3. On March 1, 2012, the Patient, an insured of FFVA, underwent a pre-authorized arthroscopic knee surgery, which was performed at Summerlin.

4. The surgery was performed by Fletcher A. Reynolds, III, M.D. Dr. Reynolds dictated an Operative Report wherein he described the "Procedures Performed" as:

> Right knee arthroscopy, subtotal medial meniscectomy of bucket-handle medical meniscus tear, major synovectomy, medial

> compartment chondroplasty, and abrasion chondroplasty of the inferior medial aspect of the trochlea down to bleeding bone.[5/]

The Operative Report also contained a section, "Procedure in Detail," which explained the extent of the surgery performed on the Patient's knee.

5. The Current Procedural Terminology (CPT) codes for use to bill for the Patient's procedures include:

> 29879 abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture;
>
> 29881 with meniscetomy (medial OR lateral, including any meniscal shaving); and
>
> 29875 synovectomy, limited (eg, plica or shelf resection) (separate procedure).

6. A modifier is a number added to a particular CPT code that explains the procedure and what, if anything, is unusual about it. The two modifiers at issue are "51" and "59." Modifier 51 is defined as:

> Multiple Procedures: When multiple procedures . . . are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D).

CPT 2010,® American Medical Association, Appendix A-Modifiers, page 529.

Modifier 59 is defined as:

> Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M [evaluation and management] services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

CPT 2010,® American Medical Association, Appendix A-Modifiers, page 530.

7. Summerlin submitted a bill to FFVA identifying the following CPT codes and charges for each procedure done on the Patient's knee: 29879RT ($8,338.00); 29881RT ($8,338.00); and 2987551RT ($8,338.00). Summerlin's total bill was $25,014.00.

8. FFVA paid Summerlin $8,986.60, $5,836.60 for the primary procedure (CPT code 29879RT) and $3,150.00 for the second

procedure (CPT code 29881RT), but disallowed any payment for CPT code 2987551RT.

9. FFVA issued an Explanation of Bill Review (EOBR) explaining that the total recommended allowance for reimbursement was $8,986.60. FFVA's "EOBR CODE DESCRIPTION" listed number "69" to justify its decision. As explained on the EOBR:

> 69 PAYMENT DISALLOWED: BILLING ERROR: CORRECT CODING INITIATIVE GUIDELINES INDICATE THIS CODE IS A COMPREHENSIVE COMPONENT OF CODE XXXXX BILLED FOR SERVICE(S) PROVIDED ON THE SAME DAY (29875 IS A COMPREHENSIVE COMPONENT OF 29879).[6/]

10. Summerlin timely filed a "Petition for Resolution of Reimbursement Dispute," and FFVA timely filed a "Carrier Response to Petition for Resolution of Reimbursement Dispute," each pursuant to section 440.13(7).

11. The Department issued its "Workers' Compensation Medical Services Reimbursement Dispute Determination" wherein it found that FFVA improperly adjusted the reimbursement, but only as to the charges billed for CPT code 2987551RT.

12. The uncontroverted facts are that the Patient underwent a pre-authorized arthroscopic surgical procedure to the knee. Summerlin's invoice for billing provided to FFVA accurately reflected the multiple procedures performed by the surgeon, as did the Operative Report.

13. Julie Dunn, FFVA's "medical compliance person," has worked for several insurance companies over her 25-year career. Her description of the process of reviewing medical bills and coding, a "complicated process because there's [sic] multiple resources that are adopted . . . ," is credible. However, in this instance, Ms. Dunn, who is not a professional coder (but is a member of a professional coder organization), did not review the EOBR until after Summerlin filed a reimbursement dispute. Although helpful, her testimony is not without doubt. Ms. Dunn never reviewed the Operative Report for the Patient. Further, FFVA only brought up the "59" modifier concern after the EOBR was issued, and the request for additional payment was made.

14. Arlene Cotton, the Department's registered nurse consultant, is tasked with reviewing cases where a provider is disputing the reimbursement received. Ms. Cotton holds a bachelor's degree and a master's degree in nursing. Additionally, she is a certified professional coder who has reviewed hundreds of cases involving ambulatory surgical centers. Ms. Cotton reviewed Summerlin's petition for reimbursement by reviewing the CPT codes and the Operative Report for the Patient. Summerlin properly coded the Patient's three procedures.

15. Ms. Cotton credibly explained the three procedures via the codes as follows: CPT code 29879, the primary procedure was an arthroplasty which was done in both the medial and the

patellofemoral compartments of the knee; CPT code 29881 was a meniscectomy which was done in the medial compartment; and CPT code 29875 was a synovectomy which was done in the medial aspect, the intercondylar, the anterior lateral, and the patellofemoral. Further, Ms. Cotton described two additional synovectomies (for a total of four synovectomies) performed that were detailed in the Patient's Operative Report. However, Summerlin only billed for one synovectomy.

16. FFVA's claim that Summerlin should have used modifier "59" instead of modifier "51" to "identify that procedure code 29875 was a . . . unique identifiable or a separately identifiable service" is misplaced. The Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2011 Edition (CRM ABS), requires that a surgical center use modifier 51.

17. There was no credible evidence that Summerlin incorrectly billed for the three procedures. FFVA failed to appreciate the significance of modifier "51" and failed to appropriately reimburse Summerlin.

CONCLUSIONS OF LAW

18. The Division of Administrative Hearings has jurisdiction over the parties to and subject matter of this proceeding. §§ 440.13, 120.569 and 120.57, Fla. Stat.

19. The Department is the state agency charged with administering Workers' Compensation Law, chapter 440, Florida Statutes, which directs the Department to resolve reimbursement disputes when they arise between a health care provider and the employer or carrier responsible from the provision of workers' compensation benefits to an injured employee/claimant. In this case, the Department determined that FFVA's refusal to reimburse Summerlin the additional $4,169.00 was improper.

20. Section 440.13(7) provides in pertinent part:

> (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.

21. Section 440.13 does not address which party bears the burden of proof in this proceeding. However, the general rule is that "the burden of proof, apart from statute, is on the party asserting the affirmative of an issue before an administrative tribunal." Balino v. Dep't of HRS, 348 So. 2d 349, 350 (Fla. 1st

DCA 1977); Dep't of Transp. V. J.W.C. Co., 396 So. 2d 788 (Fla. 1st DCA 1981). In this instance, FFVA petitioned the Department for affirmative relief, i.e., a determination that FFVA properly adjusted Summerlin's payment. Accordingly, FFVA, as the party asserting that it properly reimbursed Summerlin, bears the burden of proving its position by a preponderance of the evidence. Fairpay Solutions, Broadspire Servs., Inc., & Crum Servs. v. Fla. Ag. for Health Care Admin & Miami Beach Healthcare Group, LTD., 969 So. 2d 455 (Fla. 1st DCA 2007); Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996); Fla. Dep't of Transp. v. J.W.C. Co., 396 So. 2d 778, 788 (Fla. 1st DCA 1981); also see § 120.57(1)(j), Fla. Stat. ("Findings of fact shall be based upon a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute."). A preponderance of the evidence is defined as "the greater weight of the evidence" or evidence that "more likely than not" tends to prove a certain proposition. Fireman's Fund Indemnity Co. v. Perry, 5 So. 2d 862 (Fla. 1942); Gross v. Lyons, 763 So. 2d 276, 280 n.1. (Fla. 2000).

22. Section 440.13(12) provides in pertinent part:

> (a) A three-member panel is created. . . . The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by

> . . . ambulatory surgical centers. . . . Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for . . . ambulatory surgical centers, ... An . . . ambulatory surgical center . . . shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

23. Florida Administrative Code Rule 69L-7.100 incorporates, by reference, the CRM ABS. The CRM ABS states in relevant part:

> Determining Reimbursement Amounts
>
> Multiple Surgical Procedures
>
> Reimbursement shall be made for all medically necessary surgical procedures when more than one (1) is performed at a single operative session. Each procedure performed shall be identified by use of the appropriate five-digit CPT® code and listed separately.
>
> - The primary, or most clinically significant procedure, shall be reported first without appending modifier 51.
>
> - Each additional surgical procedure code shall be listed separately and reported by appending modifier 51.
>
> Multiple Surgical Procedure Reimbursement Amount
>
> To find the reimbursable amount on any additional surgical procedure(s), identify the following four (4) values:
>
> 1. The reimbursable amount of the billed primary procedure code pursuant to the policy in this Manual, and

> 2. 50% of the billed charge for the additional surgical procedure code,
>
> 3. The MRA [Maximum Reimbursement Allowances] of the billed additional surgical procedure code from the Fee Schedule in Section V, if any, and
>
> 4. The contracted reimbursement amount, if applicable.
>
> If there is a contracted reimbursement amount, reimburse the contracted amount.
>
> Otherwise reimbursement is the lesser value of either item 2 or item 3, not to exceed the value identified in item 1.

24. FFVA did not establish by a preponderance of the evidence that it properly reimbursed Summerlin for the three procedures.

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, Office of Medical Services, enter a final order affirming the Reimbursement Dispute Determination issued April 24, 2012, wherein the Department directed FFVA Mutual Insurance Company to pay a total of $13,155.60 for the reimbursement claim filed by Summerlin.

DONE AND ENTERED this 16th day of November, 2012, in Tallahassee, Leon County, Florida.

LYNNE A. QUIMBY-PENNOCK
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 16th day of November, 2012.

ENDNOTES

[1/] Summerlin should have been a party to this action, but did not intervene in the case. Based on the outcome, it does not matter that Summerlin did not get notice of or appear at the hearing.

[2/] Joint Exhibits A and B contained confidential, private medical information regarding the Patient; that information was redacted.

[3/] Although the pleading purported to be from Respondent, the certificate of service is executed by Petitioner's counsel; hence, in this instance, it was Petitioner who provided the notice, not Respondent.

[4/] Unless otherwise indicated, all references to Florida Statutes are to the 2012 version.

[5/] The knee is comprised of three compartments: medial (the inside of the knee); lateral (the outside of the knee); and patellofemoral (the area directly behind the kneecap or patella).

[6/] The EOBR contained a second "EOBR CODE DESRIPTION," number "91," and a "CARRIER EXPLANATION REASON CODE" that contained the numbers 183, 851, and 899. None of these codes were at issue, and, although the last three were briefly

discussed at hearing, none were reviewed as pertinent to the issue at hand.

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.