STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

PACIFIC EMPLOYERS INSURANCE COMPANY,

Petitioner,

Case No. 20-2121

vs.

DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION,

Respondent.
_____/

RECOMMENDED ORDER

The final hearing in this matter was conducted before Administrative Law Judge Jodi-Ann V. Livingstone of the Division of Administrative Hearings (DOAH), pursuant to sections 120.569 and 120.57(1), Florida Statutes (2019),[1] on July 20, 2020, by Zoom Conference.

APPEARANCES

For Petitioner: John R. Darin, Esquire
Bennett, Jacobs and Adams, P.A.
1925 East Second Avenue
Post Office Box 3300
Tampa, Florida 33601

For Respondent: Thomas Nemecek, Esquire
Keith C. Humphrey, Esquire
Department of Financial Services
Division of Workers' Compensation
200 East Gaines Street
Tallahassee, Florida 32399

[1] Unless otherwise indicated, all references to the Florida Statutes are to the 2019 version.

STATEMENT OF THE ISSUES

Whether the proposed agency action challenged by Petitioner improperly relies on a rule that is an invalid exercise of delegated legislative authority; and whether Petitioner has met its burden to prove that it properly adjusted a hospital's bill for implants used in connection with an injured worker's scheduled outpatient surgery when judged by a lawful standard.

PRELIMINARY STATEMENT

On June 3, 2019, the Department of Financial Services, Division of Workers' Compensation (Department or Respondent), received a Petition for Resolution of Reimbursement Dispute from Adventist Health System/Sunbelt, doing business as Florida Hospital Orlando (Florida Hospital), to resolve a reimbursement dispute pursuant to section 440.13(7), Florida Statutes.[2] On July 1, 2019, the Department received the Carrier Response to Petition for Resolution of Reimbursement Dispute from Pacific Employers Insurance Company (Petitioner).

On July 15, 2019, the Department issued a Reimbursement Dispute Determination. Petitioner timely filed with the Department a Petition for Administrative Hearing pursuant to sections 120.569 and 120.57(1). The Department referred the petition to DOAH on May 6, 2020, for the assignment of an administrative law judge to conduct a chapter 120 hearing.

On June 17, 2020, the Department filed and served a Notice to Interested Party: Adventist Health System/Sunbelt (Florida Hospital Orlando). The Notice indicated Florida Hospital's substantial interests may be affected by the final disposition of these proceedings and provided the manner for Florida

[2] The 2019 version of chapter 440 is cited for ease of reference. The statute at issue, section 440.13, has been unchanged since 2016, which is prior to the occurrence of the relevant facts of this case.

Hospital to intervene. Florida Hospital did not move to intervene and did not participate in these proceedings.

Prior to the hearing, the parties filed a Parties' Pre-Hearing Stipulation in which they stipulated to a number of facts. The agreed facts are incorporated in the findings below, to the extent relevant.

The final hearing was held on July 20, 2020, with both parties present and appearing from different locations in Florida via Zoom Conference. Petitioner presented the testimony of Amanda Wheatley (Ms. Wheatley), who was accepted as an expert in medical billing. Petitioner's Exhibits 1 through 8 were admitted into evidence.[3] Respondent presented the testimony of Lynn Metz (Ms. Metz), the Department's registered nurse consultant. The parties' Joint Exhibits A through E were admitted into evidence. The parties were reminded that, even though their individual and joint exhibits were admitted into evidence, hearsay evidence contained in the exhibits would not be relied on as the sole basis for findings of fact unless the hearsay evidence would be admissible over objection in a civil action in Florida. *See* § 120.57(1)(c), Fla. Stat.; Fla. Admin. Code R. 28-106.213(3).

At the close of the hearing, the parties were advised of a ten-day timeframe following DOAH's receipt of the hearing transcript to file proposed recommended orders. A one-volume Transcript of the final hearing was filed with DOAH on August 7, 2020. Petitioner submitted Petitioner's Proposed

[3] Petitioner's Exhibits 1 through 8 are hearsay with no predicate to support a hearsay exception, and as such, cannot be the sole basis for a finding of fact. Accordingly, Petitioner's Exhibits 1 through 7 (Comparable Invoices) and Petitioner's Exhibit 8 (CMS 2019 Statewide Average Cost to Charge Ratios for Acute Care Hospitals), although admitted, are not relied on for the truth of the statements therein.

Final Order[4] on August 10, 2020. The Department submitted Respondent's Proposed Recommended Order on August 17, 2020. Both post-hearing submittals were duly considered in preparation of this Recommended Order.

FINDINGS OF FACT

1. The Department is the state agency responsible for administration of the Workers' Compensation Law. Ch. 440, Fla. Stat. The Department has exclusive jurisdiction to decide any matters concerning reimbursement under the Workers' Compensation Law. *See* § 440.13(11)(c), Fla. Stat.

2. Petitioner is a carrier as defined by section 440.13(1)(c).

3. Florida Hospital, a non-party, is a health care provider as defined by section 440.13(1)(f) and (g).

4. Under Florida's statutory workers' compensation system, injured workers report their injury to their employer and/or workers' compensation insurance carrier. *See* Ch. 440, Fla. Stat.

5. As a condition of eligibility for payment, a health care provider who renders services to an injured worker must receive authorization from the carrier before providing treatment. The only noted exception is emergency care, in which case, if a hospital admission occurs after emergency treatment, the carrier must be notified by the hospital within 24 hours as a condition to eligibility for payment. § 440.13(3), Fla. Stat.

6. A health care provider providing necessary remedial treatment, care, or attendance to any injured worker must submit treatment reports to the carrier in a format prescribed by the Department. § 440.13(4)(a), Fla. Stat.

7. In addition, after providing treatment, health care providers must submit their bills to the carriers. These bills include line items for various

[4] Petitioner seeks a final order declaring a Department rule invalid. However, that can only be the result of a rule challenge under section 120.56, Florida Statutes. Here, the petition raised the invalidity of a rule as a defense to the proposed agency action which is challenged in this substantial interests proceeding. *See* § 120.57(1)(e)2., Fla. Stat. Proceedings initiated pursuant to section 120.57(1), including those in which defenses are raised under section 120.57(1)(e), are resolved by recommended order.

health-care-related services and supplies, such as implants, pharmacy, and X-rays.

8. The carrier may pay, adjust,[5] or dispute line items in a bill on certain conditions: 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 chapter 440, it must disallow or adjust payment for such services or error. The disallowance or adjustment may only occur if the carrier, in making its determination, has complied with section 440.13 and the rules adopted by the Department. § 440.13(6), Fla. Stat.

9. To adjust or disallow line items in a bill, the carrier must submit an Explanation of Bill Review (EOBR) to the health care provider.

10. An EOBR is the "document used to provide notice of payment or notice of adjustment, disallowance or denial by a claim administrator, or any entity acting on behalf of an insurer to a health care provider containing code(s) and code descriptor(s), in conformance with subsection 69L-7.740(13), F.A.C." Fla. Admin. Code R. 69L-7.710(1)(y).

11. If a health care provider wants to contest a carrier's disallowance or adjustment of payment, it must file a Petition for Resolution of Reimbursement Dispute Form (Petition for Resolution) with the Department within 45 days after receipt of the EOBR from the carrier. § 440.13(7)(a), Fla. Stat.; Fla. Admin. Code R. 69L-31.003.

12. Coventry Health Care (Coventry) is a third-party entity that maintains a network of contracts with health care providers. Essentially, Petitioner is a third-party beneficiary of the rates negotiated between Florida Hospital and Coventry.

[5] "Adjust" means payment is made with modification to the information provided on the bill. Fla. Admin. Code R. 69L-7.710(1)(b).

13. At all times relevant to the facts of this case, Florida Hospital and Petitioner had a Coventry-negotiated PPO contract in place. The contract permitted a five percent discount for hospital outpatient services.

14. Florida Hospital filed a Petition for Resolution with attachments, dated May 29, 2019, with the Department.

15. Through that Petition for Resolution, Florida Hospital requested resolution of disputed carrier adjustments to a bill tendered to Petitioner for payment for services rendered to a workers' compensation patient on December 26, 2018.

16. Florida Hospital's Petition for Resolution included its entire bill of charges for payment by Petitioner; however, the only items at issue are adjustments to two charges for implants that are designated on Florida Hospital's bill as C1778 and C1767.

17. Florida Hospital's bill included charges of $45,961.00 for C1778 and $161,564.60 for C1767.[6]

18. The implant charges at issue were for implants used in connection with scheduled outpatient surgery for the injured worker.

19. Petitioner does not dispute the medical necessity of the implants, nor does Petitioner dispute that the charges on the bill were Florida Hospital's actual charges for these implants pursuant to its chargemaster.

20. Instead, Petitioner asserts that the undersigned and the Department cannot use the implant reimbursement standard that was used by the Department in its proposed agency action, because that standard, promulgated as a rule, is an invalid exercise of delegated legislative authority.

[6] The parties stipulate that C1767 was divided into two line items. In this Recommended Order, the amounts billed and/or paid for C1767 are referred to as a total of the two line items.

Applicable Reimbursement Standard

21. The Department contends that the applicable implant reimbursement standard is contained in chapter 6 of the 2014 edition of the Florida Workers' Compensation Reimbursement Manual for Hospitals (Hospital Manual), promulgated as a rule and incorporated by reference in Florida Administrative Code Rule 69L-7.501. Chapter 6 contains the outpatient reimbursement schedules. The introduction to this chapter provides, in pertinent part:

> Pursuant to section 440.13(12)(a), F.S., all compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges for medically necessary services and supplies, except as otherwise specified in this Chapter. *The exception is for scheduled outpatient surgery, which shall be reimbursed at 60 percent of usual and customary charges*.
>
> *Usual and customary charges are reimbursed based on average charges of outpatient hospital bills, by CPT® code and HCPCS® Level II code, in a specific geographic area.* Please see Appendix A of this Manual for the adopted geographic modifiers by county and Appendices B and C for a listing of the Base Rates by CPT® code and HCPCS® Level II code for non-scheduled outpatient services and scheduled surgical services.
>
> In the absence of a CPT® or HCPCS® Level II procedure code in the applicable Appendix or a mutually agreed upon contract between the hospital and the insurer/employer, reimbursement shall be made at the applicable percentage of the hospital's usual and customary charge. (emphasis added).

22. Specific to surgical implant reimbursement, the Hospital Manual provides at page 23 as follows:

> Reimbursement for surgical implant(s), also referred to as "other implant" by the National

> Uniform Billing Manual, and associated disposable instrumentation required during outpatient surgery billed under Revenue Code 278 shall be determined by one of the following methods:
>
> • For those utilized during unscheduled surgeries, surgical implants and associated disposable instrumentation shall be reimbursed seventy-five
>
> percent (75%) of the hospital's usual and customary charge; or
>
> • For those utilized during scheduled surgeries, surgical implants and associated disposable instrumentation shall be reimbursed sixty percent (60%) of the hospital's usual and customary charge; or
>
> • According to a mutually agreed upon contract between the hospital and the insurer/employer.
>
> **Note**: Since there are no CPT or HCPCS level II codes for implants and associated disposable instrumentation incorporated into Appendices B or C, pursuant to the description of usual and customary charges provided in the **Introduction** of this chapter, these items are reimbursed at the applicable percentage of the hospital's usual and customary charge.

23. The Introduction section of chapter 6 properly sets forth the statutory reimbursement standard for hospitals providing scheduled outpatient surgery, "which shall be reimbursed at 60 percent of usual and customary charges." (Hospital Manual, Ch. 6 Introduction, p. 21).

24. Although the Hospital Manual correctly describes the statutory reimbursement standard as generally applicable to hospital scheduled outpatient surgery bills, the Hospital Manual nonetheless creates an exception to that reimbursement standard for implants.

25. The Hospital Manual states that in the absence of a CPT or HCPCS Level II procedure code—the tools the Department chose to measure usual and customary charges—or a mutually agreed upon contract between the hospital and the insurer/employer, reimbursement shall be made at 60 percent of the hospital's usual and customary charge.

26. Because CPT or HCPCS Level II procedure codes do not exist for implants and the Coventry-negotiated PPO contract does not specifically address reimbursement for surgical implants utilized during hospital outpatient scheduled surgeries, the Department rule provides the reimbursement standard of 60 percent of the hospital's usual and customary charge.

27. Since the statutory reimbursement standard for all compensable charges for scheduled outpatient surgeries is "60 percent of usual and customary charges" as recognized by the Hospital Manual, then that is the applicable reimbursement standard for implants used by hospitals in scheduled outpatient surgery for injured workers.

28. The portion of the Department's rule, creating an exception to the applicable reimbursement standard for implants, solely because there are no CPT or HCPCS level II codes for implants, is contrary to the statute it purports to implement.

29. Further, the substituted reimbursement standard for implants, allowing a hospital to be reimbursed at the hospital's usual and customary charges, rather than the usual and customary charges by all hospitals in the same geographical area, is contrary to the statute it purports to implement.

Petitioner's Evidence Offered to Prove "Usual and Customary Charges"

30. Both in the carrier response submitted to the Department for its Reimbursement Dispute Resolution and at the hearing in this case, Petitioner correctly contended that the appropriate reimbursement standard is "usual and customary charges" by hospitals in Florida Hospital's community/area.

31. However, neither in the carrier response nor at the hearing in this case did Petitioner offer evidence of the usual and customary charges of hospitals in Florida Hospital's community or area for implants used in scheduled outpatient surgeries.

32. Petitioner presented the testimony of its expert in medical billing, who testified that in her experience the usual and customary hospital markup for implants in Florida is 3.5 times the invoice cost of the implants. She referred to this as the "standard industry markup." Using this standard—invoice cost times 3.5—Petitioner contends that it properly adjusted Florida Hospital's bill for implants. The invoice cost for C1778 was $5,000.00 and the invoice cost for C1767 was $18,500.00.

33. Petitioner's adjustments cannot be found to be proper as it is based on a reimbursement standard that is not set forth in either the statute or the Department rule. If, as the Department's rule specifies is generally true for scheduled outpatient surgery, the proper reimbursement standard is usual and customary charges by hospitals in the provider's geographic area, then it was incumbent on Petitioner to prove it properly adjusted the charges based on the proper measure: the usual and customary charges by hospitals in the provider's geographic area for implants used in scheduled outpatient surgery.

34. Usual and customary charges are calculated based on the average charges of outpatient hospital bills in a specific geographic area. (*See* Hospital Manual, Ch. 6 Introduction, p. 21). Invoice cost times 3.5 is a different standard—a different measure—than usual and customary charges. As the Department recognized, charges for implants can vary greatly.[7] The

[7] The Department's witness, Ms. Metz, testified that the Department is unable to use usual and customary charges in Florida Hospital's geographical area when determining the amount of reimbursement for implants because it cannot determine a fixed reimbursement rate for something that has such a widely variable charge. Surgical implants, she testified, can range in cost from $25 to thousands of dollars and, as such, the Department cannot justify using a fixed rate for one particular implant. The difficulty in determining what the usual and customary charges in the community are does not relieve the Department of its responsibility to use that standard in determining the reimbursement amount.

average charge, considering all hospital charges for implants (or specific types of implants) used in scheduled outpatient surgeries in the specific geographic area, would be the usual and customary charge.

35. The Department does use a reimbursement standard that starts with the invoice cost and adds a markup for implants, but not in the context of hospital scheduled outpatient surgeries. A cost-plus reimbursement standard applies to implants used in connection with hospital *inpatient* surgeries.[8] That reimbursement standard, codified in chapter 5 of the Hospital Manual, does not apply here.

36. The Hospital Manual adopts a rule standard for defining a hospital's community, which is considered the county in which the hospital is located. Petitioner offered no evidence under any reimbursement standard that was limited to Florida Hospital's community. Instead, Petitioner's expert only offered testimony regarding the "industry standard markup" for implants statewide. For this reason, too, Petitioner's evidence fails to address the reimbursement standard it says is applicable.

CONCLUSIONS OF LAW

37. DOAH has jurisdiction over the parties and the subject matter of this cause pursuant to sections 120.569 and 120.57(1).

38. The burden of proof in an administrative proceeding, absent a statutory directive to the contrary, is on the party asserting the affirmative of the issue. *Dep't of Transp. v. J.W.C. Co.*, 396 So. 2d 778 (Fla. 1st DCA 1981); *see also Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co.*, 670 So. 2d 932, 935 (Fla. 1996). The standard of proof is the preponderance of the evidence standard. § 120.57(1)(j), Fla. Stat.

[8] "Reimbursement for surgical implant(s), also referred to as "other implant" by the National Uniform Billing Manual, required during inpatient hospitalization billed under Revenue Code 278 shall be sixty percent (60%) over the manufacturer's acquisition invoice cost for the implant(s)." (Hospital Manual, Ch. 5, p. 18).

39. As the party asserting the affirmative of the issue, Petitioner has the burden of proving by a preponderance of the evidence, that it made a proper adjustment of payment to Florida Hospital's medical bill regarding the surgical implant charges for items C1778 and C1767.

40. The Department has jurisdiction over disputed workers' compensation claims pursuant to section 440.13(7) and chapter 69L-31.

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

> (a) Any health care provider who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 45 days after receipt of notice of disallowance or adjustment of payment, petition the department 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 department results in dismissal of the petition.
>
> (b) The carrier must submit to the department within 30 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit such documentation to the department within 30 days constitutes a waiver of all objections to the petition.
>
> (c) Within 120 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.

42. Pursuant to section 440.13(12), a three-member panel was established to determine statewide reimbursement allowances for treatment and care of injured workers. Section 440.13(12) provides, in pertinent part:

> (12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—
>
> (a) A three-member panel is created, consisting of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which shall not exceed 23 hours. *All compensable*

> *charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges, except as otherwise provided by this subsection. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.*
>
> (b) *It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:*
>
> 1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.
>
> 2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.
>
> 3. *Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges.* (emphasis added)

43. Pursuant to its rulemaking authority in sections 440.13(12), 440.13(14), and 440.591, the Department promulgated rule 69L-7.501 to implement section 440.13(7), (12), and (14). Rule 69L-7.501 incorporates by

reference the Hospital Manual, which includes the applicable reimbursement schedule created by the panel. The Introduction section of chapter 6 of the Hospital Manual provides the general reimbursement schedule for scheduled outpatient surgery and provides a standard for "usual and customary":

> *Pursuant to section 440.13(12)(a), F.S., all compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges for medically necessary services and supplies, except as otherwise specified in this Chapter. The exception is for scheduled outpatient surgery, which shall be reimbursed at 60 percent of usual and customary charges.*
>
> *Usual and customary charges are reimbursed based on average charges of outpatient hospital bills, by CPT® code and HCPCS® Level II code, in a specific geographic area.* Please see Appendix A of this Manual for the adopted geographic modifiers by county and Appendices B and C for a listing of the Base Rates by CPT® code and HCPCS® Level II code for non-scheduled outpatient services and scheduled surgical services.
>
> *In the absence of a CPT® or HCPCS® Level II procedure code in the applicable Appendix or a mutually agreed upon contract between the hospital and the insurer/employer, reimbursement shall be made at the applicable percentage of the hospital's usual and customary charge.*
>
> In the event that a CPT® code or HCPCS® Level II code is substantially revised due to the creation of a new CPT® code or HCPCS® Level II code or a new CPT® code or HCPCS® Level II code is created in a CPT® manual released subsequent to the applicable CPT® manual incorporated by reference by rule, the hospital may bill and the insurer shall reimburse, subject to any other provision of this manual, statute, or applicable rule, such substantially revised or newly created CPT® code

> or HCPCS® Level II code at the applicable percentage of the hospital's usual and customary charge, as described above. (emphasis added)

44. Chapter 6, page 23, of the Hospital Manual goes on to create a carve-out exception for surgical implant reimbursements. It sets forth as follows:

> Reimbursement for surgical implant(s), also referred to as "other implant" by the National Uniform Billing Manual, and associated disposable instrumentation required during outpatient surgery billed under Revenue Code 278 shall be determined by one of the following methods:
>
> • For those utilized during unscheduled surgeries, surgical implants and associated disposable instrumentation shall be reimbursed seventy-five percent (75%) of the hospital's usual and customary charge; or
>
> • For those utilized during scheduled surgeries, surgical implants and associated disposable instrumentation shall be reimbursed sixty percent (60%) of the hospital's usual and customary charge; or
>
> • According to a mutually agreed upon contract between the hospital and the insurer/employer.
>
> **Note**: Since there are no CPT or HCPCS level II codes for implants and associated disposable instrumentation incorporated into Appendices B or C, pursuant to the description of usual and customary charges provided in the **Introduction** of this chapter, these items are reimbursed at the applicable percentage of the hospital's usual and customary charge.

45. This exception, based on implants not having an associated CPT or HCPCS level II code, is not supported by statute. There are two germane references to hospital outpatient "charges" in section 440.13(12): The first, as set forth in section 440.13(12)(a), is that "[a]ll compensable charges for

hospital outpatient care shall be reimbursed at *75 percent of usual and customary charges, except as otherwise provided by this subsection.*" (emphasis added). The second, one of the "revisions" to carry out the Legislative intent in section 440.13(12)(b), is that "[o]utpatient reimbursement for scheduled surgeries shall be reduced from *75 percent of charges to 60 percent of charges*." § 440.13(12)(b)3., Fla. Stat. (emphasis added).

46. The statute does not define the term "charges" in section 440.13(12)(b)3. or "usual and customary" in section 440.13(12)(a).

47. Where the Legislature has not defined words or phrases used in a statute, they must be construed in accordance with their common and ordinary meaning. *Donato v. American Tel. & Tel. Co.*, 767 So. 2d 1146 (Fla. 2000). The plain and ordinary meaning of a word may be ascertained by reference to a dictionary. *Green v. State*, 604 So. 2d 471 (Fla. 1992). The term "charge" is defined as a "[p]rice, cost, or expense." *Black's Law Dictionary* 248 (8th ed. 2004). The dictionary definition of the term "charge" as used in section 440.13(12)(b)3. is helpful, but still leaves the statute, if read on its own, ambiguous, as it does not provide guidance as to whose or what prices, costs, or expenses it refers.

48. Section 440.13(12)(a) states that all compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges, except as otherwise provided by "this subsection." The subsection in (12)(b) adopts "revisions" to carry out the Legislative intent of reducing hospital reimbursements. One of the revisions is in section 440.13(12)(b)3. which reduces outpatient reimbursement for scheduled surgeries. It plainly states that when the outpatient care is related to a scheduled surgery, the charges should then be reduced from 75 percent to 60 percent.

49. The language used in the Hospital Manual provides clarity regarding the meaning of "usual and customary charges" referenced in section 440.13(12)(a). The Hospital Manual defines "usual and customary charges" as

the *average charges of outpatient hospital bills, by CPT® code and HCPCS® Level II code, in a specific geographic area*." (emphasis added). This is in line with the dictionary definition: "[u]sual" is defined as "[o]rdinary; customary" and "[e]xpected based on previous experience." *Black's Law Dictionary* 1579 (8th ed. 2004); "[c]ustomary" is defined as "[a] record of all of the established legal and quasi-legal practices in a community." *Id.* at 413.

50. The reference to "charges" in section 440.13(12)(b)3., does not repeat the modifier "usual and customary"; however, that does not mean that it does not apply. Instead, section 440.13(12)(b)3. is the "otherwise provided" exception to the standard provided in 440.13(12)(a). Statutes related to the same subject matter must be read in *pari materia*. *Hill v. Davis*, 70 So. 3d 572, 577 (Fla. 2011). "Where, as here, the Florida Legislature has provided a unified and comprehensive statutory scheme, this Court will 'attempt to follow the requirements that it has set forth.'" *Id.* (quoting *E.A.R. v. State*, 4 So. 3d 614, 629 (Fla. 2009)).

51. The only reference to "75 percent" in this entire statutory section is to section 440.13(12)(a)'s "75 percent of usual and customary charges" which deals with the same subject matter—that is, reimbursements related to outpatient care.

52. It is clear, by reading both section 440.13(12)(a) and (12)(b)3., that the charges referenced in (12)(b)3. that are being reduced from 75 percent to 60 percent are "usual and customary charges." The lead-in language in paragraph (12)(b) makes it clear that (12)(b)3. was adopted as a "revision" to reduce reimbursement for hospital outpatient care provided by (12)(a).

Section 120.57(1)(e) Defense

53. Section 120.57(1)(e)1. provides that an administrative law judge and an agency may not base agency action that determines the substantial interests of a party on a rule that is an invalid exercise of delegated legislative authority.

54. The Department, in rule 69L-7.501 (the Hospital Manual), adds its own modifier to the term "charges" as used in section 440.13(12)(b)3. In the context of implants used in outpatient scheduled and unscheduled surgeries, the rule changes the "charge" to the "*hospital's usual and customary* charge."

55. An existing rule is an invalid exercise of delegated legislative authority if the rule "enlarges, modifies, or contravenes the specific provisions of law implemented." § 120.52(8)(c), Fla. Stat. To determine if a rule contravenes the implementing statutory authority, both the statute and rule must be reviewed to assess whether the rule gives effect to the implementing law and whether the rule interprets the law's specific powers and duties. *See Bd. of Trs. of Int. Imp. Trust Fund v. Day Cruise Ass'n*, 794 So. 2d 696, 704 (Fla. 1st DCA 2001).

56. The statute requires a calculation based on the usual and customary charges in the hospital's geographical area. The rule, on the other hand, requires a calculation based on the hospital's usual and customary charges. Where there is a conflict between a statute and an administrative rule, the statute takes precedence. *See State of Fla., Dep't of Ins. v. Ins. Servs. Off.*, 434 So. 2d 908 (Fla. 1st DCA 1993); *One Beacon Ins. v. Ag. for Health Care Admin.*, 958 So. 2d 1127 (Fla. 1st DCA 2007).

57. Here, although the general reimbursement rule for hospital scheduled outpatient surgeries is consistent with the statutory reimbursement standard, the carve-out exception for implants is contrary to both the statute and the Department's general reimbursement rule. The Department's implant carve-out exception requires calculations not based on a percentage of the usual and customary charges in the hospital's geographical area, but rather, on a percentage of the hospital's usual and customary charges. This part of the rule is an invalid exercise of delegated legislative authority and cannot be the basis for determining Petitioner's substantial interests.

Conclusion

58. Petitioner met its burden of proving its section 120.57(1)(e) defense, and the rule standard for scheduled outpatient implant reimbursement cannot be applied. Instead, the reimbursement standard is 60 percent of the usual and customary charges for implants in Florida Hospital's county.

59. Petitioner's adjustments to Florida Hospital's charges for implants were not based on a reimbursement standard set forth in either the statute or the Department's rule. Moreover, Petitioner failed to present any evidence of the usual and customary hospital charges for implants used in scheduled outpatient surgeries in Florida Hospital's county. In failing to do so, Petitioner did not meet its burden of proving that it properly adjusted its payment of Florida Hospital's bill.

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 dismissing the Petition for Administrative Hearing.

DONE AND ENTERED this 18th day of September, 2020, in Tallahassee, Leon County, Florida.

JODI-ANN V. LIVINGSTONE
Administrative Law Judge
Division of Administrative Hearings
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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.