STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

FLORIDA SOCIETY OF AMBULATORY SURGICAL CENTERS, INC.; HCA HEALTH SERVICES OF FLORIDA, INC., d/b/a OAK HILL HOSPITAL; HSS SYSTEMS, LLC, d/b/a PARALLON BUSINESS PERFORMANCE GROUP; AND AUTOMATED HEALTHCARE SOLUTIONS, INC.,

Petitioners,

vs.

Case No. 17-3025RP
17-3026RP
17-3027RP

DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION,

Respondent,

and

ZENITH INSURANCE COMPANY; BRIDGEFIELD CASUALTY INSURANCE COMPANY; BUSINESS FIRST INSURANCE COMPANY; and RETAIL FIRST INSURANCE COMPANY,

Intervenors.

_____/

DEPOSITION OF:	CHARLENE MILLER
AT THE INSTANCE OF:	Petitioners
DATE:	July 6, 2017
TIME:	Commenced: 9:00 a.m.
LOCATION:	Hartman Building 2012 Capital Circle Southeast Tallahassee, Florida
REPORTED BY:	ANDREA KOMARIDIS Court Reporter and Notary Public in and for the State of Florida at Large

APPEARANCES:

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ALSO APPEARING:

HELENE ROSEN

SAUL EPSTEIN

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*Huh-uh is a negative response

*Uh-huh is a positive response

D E P O S I T I O N

Whereupon,

CHARLENE MILLER

was called as a witness, having been first duly sworn to speak the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MS. HINSON:

Q Will you please state your name for the record.

A Charlene Miller.

Q And Ms. Miller, what is your job title?

A Bureau chief.

Q Here at the Division --

A Yes.

Q -- of Workers' Comp?

Okay. I'm Jennifer Hinson, and I represent Oak Hill and Parallon in this matter, who are two of the petitioners.

Have you had your deposition taken before?

A Yes.

Q Okay. So, you understand the process. You have to answer out loud because it's difficult for the court reporter to get head nods. Same with uh-huh and huh-uh. So, yes or no, if you don't mind.

And only one of us can talk at -- at once because it's hard for her to get everything down. I'm guilty of talking over folks. So, I'll do my part. Forgive me.

And if you don't understand a question that I ask, let me know and I can or rephrase it or better explain it for you.

A All right.

Q How long have you been in your current position here at the Division?

A A little over a year.

Q And what did you do before that?

A I worked for the Division as an operations review specialist, I think, or analyst, one of the two.

Q And what was that? What did that entail?

A It was part of the Electronic Data Interchange, the EDI team, triage and training.

Q Very good. And what are your current job duties?

A There's a lot. I am responsible for overseeing the Bureau of Monitoring and Audit. Within that bureau, there is the audit section. There is a permanent total section known as the "PT," and then we have the CPS team, which does penalties based upon filings by the insurers. And then we have a medical

service section.

Q And can you tell me a little bit more about what the CPS team does?

A The penalty section is responsible for -- there's a computer database that reviews form filings that are required by the Division. First reports of injuries come in. And if those reports are late-filed, then there's a penalty that is assessed.

There's medical batches that come in from the insurers or the entity that represents that particular carrier. And timely filing, timely payment -- if they hit on those two things, then there are penalties that are assessed, which requires that carrier or entity acting on behalf of that carrier to go in and review those medical batches.

Q Okay. So, the individual, I guess, entities that are subject to penalties under your CPS team are employers, carriers, and healthcare providers? Or just employers and carriers?

A It's just the employer and the carriers.

Q Okay. Is there any other section within the Division that covers penalties for employers and carriers or is it just yours?

A I believe the Bureau of Compliance is responsible for making sure that the carrier or -- or

employer has appropriate insurance. And regarding the penalties -- I would not be an expert on that, but I believe that there are penalties assessed with that as well.

Q Okay. So, do the penalties that your CPS team handles -- are those that -- some of those that stem from the medical services section and what that section does with the filing of petitions?

A No.

Q No.

A No, they're two separate.

Q Okay. Who handles penalties -- like, for instance, overutilization by healthcare providers or, you know, a pattern of untimely or inappropriate payments by carriers -- what section within the Division handles those sorts of things?

A It -- it just depends. If it is found within an audit -- an audit is where we have auditors that go on-site or they can do remote with the insurance entity. And if there are things that are found within that audit, they could generate a non-willful $2500 penalty. So, it just depends.

Overutilization is something that could transpire out of the medical services section, but that requires an EMA, a medical expert, to evaluate whether

utilization is occurring.

So, there are multiple ways that can derive it to that answer. It's -- it's not a -- I don't think it's a simple answer.

Q Okay. And explain to me what the medical section -- or excuse me -- the medical services section does.

A The medical services section is responsible for evaluating and determining reimbursement disputes that come in. We also handle questions that come in from healthcare providers regarding billing. Sometimes we get questions from the employer on what they can be charged. So, we answer questions along that line.

We also provide education as to the appropriate EOBR codes that appear or should appear; the requirements of what it specifies within EOBR that's outlined.

They make determinations. Obviously, we're doing depositions. They're responsible, in some part, for getting guidance from our legal department in creating amendments to some of the administrative rules.

Q Okay. And what has your involvement, since you've been in this role, been in the rulemaking process with regard to the proposed rule? And just to clarify, my clients are only challenging Paragraph 1 of

69L-31.016.

A Okay.

Q So, I know some of the other petitioners here have challenged others, but my questions, unless I state otherwise, are going to pertain to that, so --

A Very well.

Q What has been your role, in your current position, with regard to the rulemaking process for that rule?

A My role has been to learn and to participate. Obviously, when you take over a new position, there is a learning curve. So, this opportunity has been an educational opportunity for me.

I have participated in conferences with the director or assistant director; our legal counsel; as well as the senior management analyst within the medical services section, Theresa Pugh; and the Workers' Comp policy coordinator, Brittany O'Neil. And we have sat down and reviewed the recommendations and -- and the comments that have come out of workshops and hearings.

So, I have participated in that aspect.

Q Okay. And have you drafted any part of the rule based on, maybe, comments? Have you been engaged in the redrafting or amending of the rule?

A I would like to say I was responsible for the

edit, not necessarily drafting the language.

Q Okay.

A But editing it and getting it ready to go down to downtown for that legal team to review.

Q Okay.

A So, the edification.

Q Okay. Do you know when the rulemaking process started for that rule?

A Probably am not the best-qualified candidate to answer that. I would say maybe in December of 2015 or a little bit prior.

Q Okay.

A But Pam Macon would be able to address that question.

Q Yeah, that's fair. Our records show it was 2014, but I understand that you weren't in that role. So, you wouldn't have knowledge of that.

When did your involvement in the process begin?

A June of 2016. I think I participated in the second workshop, perhaps.

Q Okay. And I know you said medical services section handles the petitions that come in and reviews the reimbursement disputes, correct?

A Yes.

Q Okay. Were you involved in any of that before you took over in your current role?

A No.

Q Okay. So, would it be June 2016 that you began being involved --

A Yes.

Q -- in that area? Okay.

And what is your role currently in that process? I know you're the bureau chief, but what is your -- what do you actually do, if anything, in the --

MS. GALLAGHER: In respect -- with respect to the rule?

MS. HINSON: Yeah -- no, in respect to the dispute-resolution process.

MS. GALLAGHER: Oh, okay.

(Laughter.)

THE WITNESS: The only thing that I -- I am available if there is a situation where the nurse is unclear on the direction using the administrative rules and the 440.

If there's a situation that they're unclear on how to address that, then we would roundtable -- and "we," as in the defense attorney, myself, Mr. Sabolic, and Theresa Pugh, with the nurse case managers. We would sit down and discuss that case

and get a legal perspective on how to address that situation.

That's the limit of my involvement with reimbursement disputes.

BY MS. HINSON:

Q Okay. What sort of defense attorney?

A Our legal counsel.

Q Oh, in-house.

A In-house.

Q I see. I see. Okay.

And can you give me an example of one of those issues that comes up that you resolve that way?

A We currently have a healthcare provider that we have -- the Division has been actively involved in disputes since January maybe of this year or last year, of 2016. And some of the petitions that they have filed are a little -- they're -- they're not typically what has been coming in. So, it requires us to obtain a legal opinion to make sure that the reimbursement is appropriate and should be applied.

Q How are they not typical? Like, has something changed?

A We had seen an increase in pharmacy petitions. And that is not something that has occurred for quite a long time, regarding compound drugs. And it came down

to authorization or not authorized. So, those are some things that we have not -- the medical service section had not seen for a while.

Q Okay. And when did that pickup start or that change start?

A I'm -- I'm going to say that we noticed -- the Division noticed it before August of last year. It was mentioned in the Division's conference, at the Work Comp conference. If you had attended, we put the carriers on notice that there were things that were coming into play that they needed to have an awareness of.

But I do believe that some of the prescriptions were written maybe in January of 2016. Not -- not quite sure on that date.

Q Okay. How many reimbursement disputes does the Division review annually?

A Off the top of my head, I don't know. I do know that we have an accomplishment report that we provide every year. And that -- that figure should be in there.

MS. HINSON: All right. I have a few questions about this report. I'm sorry I don't have copies for everybody, but I can pass it around before we start. It's the report to the three-member panel. It was provided to us by Mr. Nemecek

during discovery.

You want to take a look before --

MR. NEMECEK: Yeah.

MS. HINSON: -- Ms. Miller looks at it?

MR. NEMECEK: (Examining document.)

Okay. Thank you.

THE WITNESS: Uh-huh.

BY MS. HINSON:

Q Okay. Let's go to Page 3 of 5.

A Uh-huh.

Q So, Page 3 says that -- let's see. Under the heading "Resolution of Reimbursement Disputes," there's two paragraphs above the table. And the first sentence says that the medical services section received 5,526 reimbursement disputes.

MS. GALLAGHER: Which one are you on, Jen? I'm sorry.

MS. HINSON: It's Page 3 of 5. And it's the second paragraph under "Resolution of Reimbursement Disputes."

MS. GALLAGHER: Okay. Got it.

BY MS. HINSON:

Q Yeah. And I just -- I have a question because I don't quite understand this. It says that you received 5,526 reimbursement disputes in '15-'16, and

you closed a total of 18,103 petitions. So, am I -- maybe I don't know what reimbursement disputes is vis-a-vis petitions, but if you got 5500 in --

A Okay.

Q Where does the 1800 number come from -- or 18,000?

A If you go back to that paragraph, it says, received during the fiscal year of '15-'16.

Q Uh-huh.

A The 18,103 -- it doesn't state that that number was necessarily received in Fiscal Year '15-16, correct?

Q Are you asking me a question?

A Yes. Yes.

MS. GALLAGHER: Backlog. Backlog.

THE WITNESS: Yeah. Yes.

BY MS. HINSON:

Q Oh. So, it --

A So --

Q Okay. So, is your backlog your answer?

A Well --

Q Is it backlog?

A There -- there was a backlog, but it's specific to closed. A petition was closed in that same time period does not necessarily mean that it was

received within that fiscal year.

Q Okay. Well, you've answered --

A But there --

Q Fine. You've answered my question. I just didn't understand it.

So -- so, all these petitions, then, at least theoretically, came in before 2015-'16?

A That, I'm not sure about. You could ask Pam Macon that because she was the bureau chief at that time.

Q Okay.

A But there was a backlog of petitions.

Q Was there a particular reason why there was a backlog of petitions?

A Again, you would have to address that with Pam. I -- I don't know what caused the backlog.

Q Okay. And when it says here that, of the 18,000, 9,570 resulted in the issuance of determinations, and then the 8,533 resulted in dismissals -- can you tell me what the difference between a determination and a dismissal is?

A Well, a determination would -- would be based on the fact that there was a -- a document that was sent out to the petitioner and the insurance entity outlining what the medical service section was going to recommend.

And a dismissal could be generated for multiple reasons: a notice of a deficiency -- I have no idea what falls behind those dismissals.

Q So, the determination could be that a carrier underpaid or that a carrier paid appropriately or even overpaid, right?

A Could be.

Q Okay. Let's turn to Page 4. The bottom paragraph there, in about the middle of it, it talks about the number of petitions dismissed due to untimely filing. It says it increased by 741 percent that year. Do you have any idea why it increased so heavily?

A Based upon Page 4 of 5, the following --

Q Uh-huh. Yes.

A The number of petitions dismissed due to untimely filing increased by 741 percent from 515 last year to 4,330. The number of petitions dismissed due to deficiencies, failure to cure deficiencies, and the documents submitted to the Division in support of the petition of resolution of reimbursement disputes.

So, I can only go by what has been written in this report as to why that would increase. The untimely filing -- I would have no understanding of what caused that.

Q Okay. Have you seen similar increases since

you've had this position?

A I have not. We have not done the end of the fiscal year. June is actually the end of the fiscal year for '16-'17. So, we have not done those reports yet.

Q Okay. And you haven't been a party or heard any discussion about this 741-percent increase.

A To my knowledge, no.

Q Okay.

A And again, that's probably something that you could ask Pam about.

Q Okay. Then there's a couple of tables on Page 5 that I would like to go through with you. My questions are similar to what I just asked. On, for instance, the top table, "failure to cure deficiency" -- do you see that category?

A Yes.

Q And it went, in '14-'15, from 624 to 2,633. Do you have any idea why it jumped like that?

MR. DOUGLAS: Form objection.

A I would say you would need to go back to Page -- perhaps Page 3 of 5 where it talks about the number of petitions that were received in for 2015-'16 and the number that was closed. Perhaps that is a reason for that increase.

Outside of that, I don't have knowledge of that.

Q Okay. There were a lot more received in '14-'15 than in '15-'16. So, I'm not sure that explains it. But is that something you think Pam would be able to speak to?

A Yes.

Q Okay. And in that same table, on the fourth row down, there's a category called "other reason." Do you know what that other reason is?

A Not specifically.

Q Is that a catch-all? Is that a bucket that certain petitions go in?

A Possibly.

Q Okay.

A If it doesn't meet the other criteria.

Q Okay. And then let's go down toward the bottom of that same table, and there's a managed-care section. And there's a marked decrease. If you look at the years '13-'14, there were 274 petitions dismissed for the reason of managed care. And then, in '14-'15 and '15-'16, it goes to two and five. Do you see that?

A No, I'm sorry. Where are you?

Q Right here (indicating).

A Okay.

Q Right. So, it goes from 274, and then the two following fiscal years, it goes to two and five.

My first question is: What is that managed-care category?

A I specifically don't know.

Q You don't know what this category is? So, when you look at this table, you wouldn't know how to explain it.

A I -- I'm not willing to define what managed care is because I don't have knowledge of the petitions relating to that managed care.

Q Okay.

A And again, you have to look at the time frames of when that came into place.

Q I don't understand that. What -- what do you mean?

A Well, '15 -- '15-'16, right? Fiscal Year '15-'16.

Q Uh-huh.

A I started on board as the bureau chief in June of 2016. So, the data that's represented occurred prior to me taking over this position.

Q Yeah.

A So, you're asking me to evaluate, correct?

Q No, I'm asking you what the bucket of managed care means, which I feel like you, at least at this point, should be able to answer. So, I don't know if -- when I'm looking at this, I have no idea what it means when it says "managed care." And I don't -- I don't even know -- what does it mean that a petition was dismissed for managed care?

I mean, that's what this is saying. It says, at the heading: Petitions dismissed by reason and fiscal year. And the reason is over here on the left. And the reason is listed as managed care.

And all I'm asking you is -- I don't know what that means. Why would it be dismissed for managed care?

A Well, if it's managed care and they were not doing petitions, they were dismissing.

Q If they weren't doing petitions?

A If the medical service section has indicated on this chart that it is under the managed-care bucket, and specifically to Fiscal Year '14-'15, and it's indicating the number two, then the assumption could be made that the petition dismissed in '15-'16 for managed care is two.

Q I'm asking you what managed care means. I -- I don't know -- what does it mean --

MS. GALLAGHER: The definition.

Q Yeah. Well, what does it mean when the petition is dismissed for managed care? Give me an example. In today's world, with you at the helm, if you dismiss something for managed care, what does that mean? I don't even know what it means.

A If it's a managed-care arrangement. If there is -- if there is evidence that provides that it is a managed-care arrangement.

Q You dismiss it?

A I believe currently that there is a determination that is made that addresses the specifics of outlined reimbursement as it would be applied to the MRA. And that is provided. But addressing whether or not it is a valid managed care is not what's going to be on that determination.

Q Okay.

MS. GALLAGHER: (Whispering.) What's an MRA?

BY MS. HINSON:

Q What's an MRA?

A Maximal reimbursement allowance, MRA.

MS. GALLAGHER: Is she saying basically --

MS. HINSON: Can we go off record for a second?

(Discussion off the record.)

MS. HINSON: Okay. Julie, you want to ask

that question when it comes to your turn?

MS. GALLAGHER: Sure. Yeah.

MS. HINSON: Okay. Very good. All right.

BY MS. HINSON:

Q So, on that same page, on Page 5, there's a paragraph between the two tables. And it says, "The medical services section discovered that the healthcare provider had been underpaid in 85.5 percent of all determinations issued for Fiscal Year 2015-'16."

So, the way I read that is, of all of the petitions that were filed in that year, 85.5 percent were found to have been underpaid by the carrier; is that correct?

A That would be my assessment, yes.

Q Okay. In the table at the bottom, there are four sections. The top one is "underpayment." And it looks like -- if you look at the first year on this chart, it's FY '11-'12. There were 3,000 underpayments -- excuse me -- 3,095 underpayments. And then in '15-'16, there were 8,189 that were underpaid.

Do you have any idea why there was such a large increase over that time period?

A I don't --

MR. DOUGLAS: Form objection. Overbroad and speculative.

Q You don't know?

A I don't know.

Q Okay. Now, it's my understanding that the Division is responsible for evaluating and identifying trends in payments by Workers' Comp carriers. And the example I'm going to use is trends in improper payments. You know, maybe over it -- incorrect adjustments or denials; is that correct?

MR. DOUGLAS: Form objection. Argumentative even and overbroad.

But go ahead.

Q If you understand my question, you can answer.

A Kind of -- I'm kind of -- could you specifically specify maybe a little clearly what you're asking?

Q Sure. It's my understanding that, under Florida law, the Division is responsible for identifying trends and payments by employer/carriers -- or excuse me -- carriers; is that correct?

A Yes.

Q Okay. And it's my understanding that, pursuant to Florida law, the Division is responsible for taking some sort of action when they do identify a trend. Is that your understanding as well?

A Yes.

Q Okay. Do you know whether the Division took any action based on the fact that 85.5 percent of all determinations were found to be underpaid?

MR. DOUGLAS: Form objection. Predicate. Go ahead.

A By issuing determinations to those carriers would be the action.

Q Do you know if they did any sort of an evaluation to identify whether or not this was a trend, other than the calculation they did to land at 85.5 percent?

A That paragraph also reads, "The discovery stems from" --

Q Oh, wait. Wait. Wait. Just -- first of all --

A Sure.

Q -- can you answer my question?

A Sure.

Q Then I'm happy to let you talk.

A Go ahead and --

Q Yeah. So, yes or no, do you know whether or not the Division took any action to assess whether this 85.5 percent underpayment was a trend?

A I have no idea.

Q Okay. And do you know if they took any action

whatsoever with employers -- or excuse me -- with carriers, based on this 85.5 percent?

A I have no idea.

Q Okay. Please --

A I was --

Q -- feel free to say what you were going to say.

A Right. The discovery also stems from data analysis to identify trends in medical billing and reporting. So, they also looked at not just -- it appears as if they -- in addition to the petitions, they also looked at medical billing to provide that analysis.

Q Okay. What is the impact of that?

A It doesn't specify in the report.

Q Oh, okay.

Do you know what the current percentage is of underpayments?

A I do not.

Q Will that information be contained in your next report that the --

A It should be.

Q -- Agency issues?

Have you been instructed to take any sort of action against carriers based on a trend in underpayments to healthcare providers?

MR. DOUGLAS: Objection. Overbroad.

A I'm not really qualified to answer that because it -- it -- with my position as a bureau chief, there are multiple things that we look at. And so, when you say, have I been instructed, I'm required by the statute to go in and -- and monitor insurance carriers through audit. If something occurs within that audit, we do provide a report, and there are penalties assessed. So, in that aspect, yes, I am given 440, and we do that.

Regarding medical, if -- if there is a trend and it's confirmed, there are provisions within the statute that we can go in and not only fine the insurance entity, but we also can go after the healthcare providers for improper billing.

And I have done that. I have sent a letter to a healthcare provider for improper billing and gave them, I believe, a month to correct the billing or we were going to start assessing fines.

So, on a case-by-case basis, when situations arise, I'm not given specific instructions from a particular person, but there are penalties that are allowed that provides the Division to do that.

Q Okay. And those were the penalties that -- or the statute that I was referring to. So, I appreciate

you clarifying that.

Since you've been in this position, have you issued any penalties to Workers' Comp carriers for underpayments?

A Yes, but probably not in the realm of what you're referring to.

Q Oh, okay. Well, then what realm?

A Indemnity.

Q I see. Okay. So, I'm talking about medical benefits, not indemnity. And to your knowledge, then, are you saying that you haven't issued any underpayment penalties to Workers' Comp carriers for medical underpayments?

A Not that I'm aware of.

Q Would that be your -- one of your shops that handles that?

A The medical services issues a determination and a -- that determination goes out. If there is no response from the carrier, then I -- I do believe that we -- well, actually, I know we get with our -- our legal division and -- and discuss the appropriate steps to take regarding that carrier.

Q Okay. And do you -- 85.5 percent underpayments seems high to me. What does that figure mean to you? Does it seem high to you?

MR. DOUGLAS: Objection. Lack of predicate, vague. Ambiguous. Overbroad. Lacks the context, including the total number of medical bills paid in the state of Florida and reviewed by the Division of Workers' Compensation, and only includes those within the small parameter of reimbursement petitions by providers and not-otherwise-dismissed, including the 45 percent that you referenced that were dismissed out of hand.

BY MS. HINSON:

Q What does the 85.5 --

MS. GALLAGHER: That's right.

Q -- percent mean to you?

MS. GALLAGHER: That's right. That's exactly what it represents.

MS. HINSON: Yeah. Yeah. We don't -- we don't disagree with you on that, Ralph.

(Laughter.)

BY MS. HINSON:

Q What does the 85.5 figure mean to you? Do you feel it's high?

MR. NEMECEK: Form.

MR. DOUGLAS: Same. Argumentative.

A Well, I would have to say that, if I'm looking at the totality of the medical bills that are received

in, it could be a small number. That 85 could represent a small number. If there was a limited amount of medical bills that were received in, it -- it could be -- the 85 percent could be a high number. It just depends on what the influx of bills that are received in.

Q Right. No, I understand that.

A So --

Q Yeah.

A So, it's hard to say whether or not that could be -- depending on the data that you're looking at, that 85 percent could be insignificant, if you have a large pool of data. If you have a small pool of data, then the 85.5 percent could be a large number.

Q Correct. But 85 percent of any number is a lot, correct?

MR. DOUGLAS: Form objection. Argumentative.

(Simultaneous speakers.)

MR. DOUGLAS: There's hundreds of thousands of bills.

THE WITNESS: (Laughter.) I don't -- I don't --

MS. GALLAGHER: We're not talking about bills.

MS. HINSON: Yeah, and --

MS. GALLAGHER: We're talking about dispute

resolutions.

MS. HINSON: Let -- let's keep the objections to actual valid deposition objections --

MS. GALLAGHER: Yeah. Right.

MS. HINSON: -- and not testimony.

MS. GALLAGHER: Yeah.

THE WITNESS: I think that really calls for a legal assessment, but 85.5 percent, it -- it could contemplate -- could contemplate a high number. And that would be my response.

BY MS. HINSON:

Q Okay. That's fair.

A Thank you.

(Laughter.)

Q Now, at some point -- and I think it was prior to you being in your current role -- the Division stopped making determinations when there was a managed-care or a reimbursement contract alleged in the petition process that your MSS team handles, correct?

A Yes.

Q Okay. And do you know when they made that decision or when that began to occur?

A It is my understanding that, November of 2006, the managed care was excluded from filing petition reimbursement disputes. I believe that's when it

started, in 2006. The medical services section did not render a decision from November of 2006.

Q '06 or '16?

A No, I think it was 2006. And then it started back -- I think they started making medical services -- the medical service section started back in maybe October of 2014.

Q Well, right, because we know that there was a more-recent period than 2006 where petitions were filed and there was a managed-care arrangement or a contract involved, and the Division made a determination, right?

So, you're just saying that it stopped for a time period; and then you think about 2014 is when they started doing it again?

A Yes.

Q Okay. And then when did they stop after that? To your knowledge.

MR. NEMECEK: Form.

A I'm not the -- the most expert on that. Pam Macon would probably be able to address that --

Q Okay.

A -- when -- when they stopped making a determination -- or actually, in your words, determination.

Q Okay. Were you involved in that decision to

stop making those determinations?

A I was -- I was not.

Q Okay. Do you know why the Division started handling those types of petitions differently? And I'm referring to the petitions that involve the managed-care arrangement or contract.

A It is my understanding that there was discussions between Ms. Macon, Mr. Sabolic, Mr. Holloman, and legal from downtown. And on the recommendation of legal, they've asked the Division to review addressing petitions with the managed care and contracts in place.

Q Okay. And I see you mention Ms. Macon again and Mr. Sabolic. And we've got their depositions coming up. To your knowledge, were they more-intimately involved than you in this process, in the review?

A In starting this -- the reimbursement dispute 31? Yes.

Q Okay. And has there been an impact or an effect on the Division since they stopped -- since they started handling those disputes differently?

MR. NEMECEK: Form.

MS. HINSON: What -- tell me what --

THE WITNESS: In what way?

MS. HINSON: Hold on a second.

What -- what is the objection? What's wrong with the form?

MR. NEMECEK: "Impact" is vague.

BY MS. HINSON:

Q Do you understand what I mean?

A Well, I would like some clarification on what the impact -- specifically the type of impact that you're referring to.

Q Well, so, at some point along the way, the Division decided to start handling those disputes differently. And again, I'm referring to the ones with managed-care arrangements or contracts that have been alleged to be in place.

And so, I'm assuming that the reason that they stopped is because they were expecting there to be some result, right? Some -- some impact of some sort, right? A consequence of them stopping could be anything. And that's what I'm trying to get at.

When they stop doing that, was there no an impact? Was there an effect? Were there -- was there more work? Less work? Were you able to get rid of a few FTEs? Those are the sort of things I'm trying to get at here.

A I have -- I have no idea because we are still providing a response to those petitions based upon the

MRAs, but I haven't -- I -- I don't know. I don't know.

Q Okay. That's a fair answer.

A Okay.

Q Do you know what the Division was trying to accomplish by handling these disputes differently?

A Well, the Work Comp system is a self-executing system. And so, the Division, in governing itself in relations to the 440 and the administrative rule, actively participates in -- in trying to facilitate the self-executing system.

So, based on that, I would say that the Division is hoping that, by providing guidance of what the reimbursement would be that fell within that MRA, that both parties could, then, take that information and resolve that independently.

Q And how would that be helpful? And I'm not trying to be contrary. I just -- I don't quite understand. How would that be helpful, in your opinion?

A Well, it's providing you what the reimbursement is specified, according to the reimbursement manuals. It's providing both parties what that amount should be.

Q Under a rate that is different than the rate that's in the contract.

MR. NEMECEK: Form.

A Well, actually, it's the rate that has been agreed upon by the three-member panel. So, it is a standard reimbursement language, correct? Yes.

Q Right. So, I -- I want to know how a standardized rate -- you determining what standardized rate should apply -- helps the parties determine what's due and owing under a reimbursement contract.

A Well, it -- it's not my standard, but it is the reimbursement manual. And it's putting both parties on notice of what that reimbursement should be, if it fell within that MRA. How that is helpful to the individual is how they take that information.

Q Okay. Were you at all involved in the Department's analysis to determine whether a statement of estimated regulatory costs was needed?

A I did participate in -- in some of the conferences, yes.

Q Okay. So, you know the document that I'm --

A The SERC --

Q -- referring to? Well, not the SERC, the document titled "The Analysis to Determine Whether a SERC is Needed." And I've got it here, so I can show it to you.

MS. HINSON: Here it is. And I apologize, it's not stapled. My stapler at home wouldn't go

through that thick of a document. It's "D." It's what she has right there, Tom, and it's just what you provided in discovery and what was provided to us.

MR. NEMECEK: (Examining document.)

Thank you.

MS. HINSON: Do you want a copy of it? I actually do have an extra copy of that. You good?

MR. NEMECEK: No. No.

MR. DOUGLAS: I'm good.

MS. GALLAGHER: I'll have an extra copy.

MS. HINSON: Yeah.

Ginny, I have one extra copy.

MS. DAILEY: I have that.

MS. HINSON: You're good? Okay.

BY MS. HINSON:

Q So, what was your involvement?

A I reviewed it with Theresa Pugh, David Hershel, who was staff counsel, and Andrew Sabolic. I believe initially this was completed maybe in 2015, so -- well, I don't know when it was done.

Q Yeah. So, the one you're looking at --

A The form, I think, was published in 2015.

Q That's right. The one you're looking at actually is in response to Parallon, my client's,

submission of a lower-cost regulatory alternative.

A And what was the date of the letter?

Q That's in your packet as well. Let me find it.

A I haven't seen it. Oh, was it --

Q The date of our letter was December 28th, 2016. And we're not going to get down into the nitty-gritty. You are welcome to take the time to read that, if you want, or we can just proceed. And then, if you need to read it --

A No, you can proceed.

Q Okay. On Page 3 of the analysis to determine if a SERC is required, you see down under Paragraph G that the Agency rejected Parallon's lower-cost regulatory alternative. You see that?

A Yes.

Q Were you involved in the process of determining whether to accept or reject that?

A Yes.

Q Okay. And why did the Agency reject Parallon's lower-cost regulatory alternative? Do you know?

A I don't specifically recall what -- what the exact was, but we believed -- let's see. What is their -- (examining document). Okay. Their

alternative -- and I'm going to read from Page 2 from their -- December 28th, the alternative that Parallon proposed, "If the reimbursement dispute involves hospital services, documentation of the hospital charge master pertinent to the billed services as of the date of service, a hospital shall not be required to include such documentation with its petition, if it is certified on the petition that it maintains its charge master in the electronic database, and that the charges on the itemized statement were produced from its charge master database, as it existed on the relevant date."

Q Actually, that is a different lower-cost alternative.

A Okay.

Q Yep. It's to 31.005.

A Okay.

Q If you flip to the -- let's see. The next page, about the middle of the page --

A Okay.

Q -- is where our letter starts with 31.016 Paragraph 1. And I'll -- I'll just -- I'm happy to state for the record --

A Yes, please.

Q Yeah, that we propose that the lower-cost regulatory alternative to that section was not to adopt

the rule.

And so, my question to you is: Do you know why that was rejected?

A And this is regarding 69L-31.016?

Q Yes, ma'am.

A Okay. The Division, if -- I believe, in the 0.16 -- it's specific to contracts and managed care. And so, the Division rejected that proposed language to not strike it, but to keep it.

Q Right. Do you know why?

A Why we chose to keep?

Q Right.

A Why -- 0.16?

Q Yes.

A That we would provide determinations regarding what the reimbursement was, per the reimbursement manuals, as opposed to providing contractual dispute information.

Q So, the reason -- if you go back to the analysis to determine if a SERC is required, at Paragraph G, if you will look to see what the reason that the Department gave, they -- the reason they said it was rejected is because Parallon's lower-cost regulatory alternative consisted of a cost-based argument against the adoption of the proposed rule on

the basis that the existing rule provides a lower-cost alternative.

Do you understand that?

A (Examining document.) I believe so.

Q Okay. Can you explain it to me?

A It appears that Parallon is stating that the existing rule, which is 61L-31, provides a lower-cost alternative to the amended 69L-31 -- correct? Parallon's lowest-cost regulatory alternative consists of -- and if you go -- if I go back to reading the statement, they're asking that it not be adopted. And it's referring to 0.16, which is regards to contract and managed care as well as compensability and medical necessity.

So, Parallon was asking for us to not adopt that rule and continue with the current 69L-31.06, existing rule, which does not have that language.

Q There -- there is no existing rule, right? I mean, this is a --

A 31.

Q -- new rule?

A 30 -- yes, striking the -- the .016 and keeping -- I think it said -- the existing rule provides a lower-cost alternative.

Q Where does it say that? I'm sorry.

A Page 3, Parallon's lower-cost regulatory alternative consists of a cost-based argument against the adoption of the proposed rule on a basis that the existing rule provides a lower-cost alternative.

Q Right. I have no idea what that sentence means. That's why I'm asking you if you can clarify it. I mean, I just -- I flat-out don't understand it.

A Well, this is information or -- or recommendation that was provided by our legal counsel.

MR. NEMECEK: I don't want you to go into any sort of communications between attorney and client.

THE WITNESS: Okay.

BY MS. HINSON:

Q And I wouldn't ask you to.

A Okay.

Q So, if you perceive a question to be looking for that information, I certainly have no expectation that you would tell me any of that.

A Okay.

Q Yeah. What is the cost-based argument that this sentence refers to?

A Again, that -- the verbiage that is being provided is based upon the recommendation by -- by counsel.

Q Okay. So, as we sit here, though, you -- you

can't explain it?

A I would say that, you know, in relation to this, this information was provided by Counsel. So, that -- it's a legal opinion, to which the Division went with.

Q Okay.

MS. GALLAGHER: I -- I'm just -- I'm going to object to the assertion of a privilege.

You're asking her, as I understand it, how that sentence explains why that cost-based argument was rejected.

MS. HINSON: Right.

MS. GALLAGHER: And she's saying it was rejected on the basis of legal advice. Well, that's the Department's obligation. And they put it out there as public record. And I think we're entitled to know what that recommendation was.

You don't have to phrase it in terms of, this is what the attorney said, but we need to know what the recommendation was as to why the cost-based argument was rejected because this sentence doesn't say why.

So, I -- if it came from a lawyer, if it came from Tanner Holloman, if it came from the Governor's office, somebody needs to say what --

why the Division's -- why the Division rejected that argument.

So, I don't think the claim of privilege is properly asserted.

MR. DOUGLAS: And I'm not -- I get what you're saying. I'm not counsel for the Department.

MS. GALLAGHER: No, I know.

MR. DOUGLAS: But is she even the witness for that, given the names you just dropped?

MS. GALLAGHER: I don't know. She -- if she doesn't know why --

MR. DOUGLAS: She says --

MS. GALLAGHER: If she doesn't know why, she can say she doesn't know why, but they --

THE WITNESS: I cannot.

MS. GALLAGHER: You instructed her not to answer based on --

MR. DOUGLAS: That's kind of why --

MS. GALLAGHER: -- a communication. Yeah. Okay.

MS. HINSON: Okay.

MS. GALLAGHER: Yeah.

MS. HINSON: If you don't know, that's a fine answer.

(Simultaneous speakers.)

THE COURT REPORTER: One at a time.

(Discussion off the record.)

THE WITNESS: My response is, I cannot.

THE COURT REPORTER: Thank you.

THE WITNESS: You're welcome.

BY MS. HINSON:

Q Were you involved in answering any of the questions in the analysis to determine if a statement of estimated regulatory costs is required? For instance, No. 1 says, "Will the proposed rule have an adverse impact on small business?" The answer the Division gave is, no. Were you involved in giving that -- that answer?

A Initially, I was not. I -- I believe the SERC was done in -- I'm not sure when the initial one was done. As far as the amended one, I believe there was some confusion as to one was not done. I did participate with Paul, the attorney that oversaw the workshops and hearings, as well as Theresa Pugh and myself, and Mr. Hershel, who is legal counsel, and Mr. Sabolic.

Q Okay. I haven't seen a SERC. I mean, was there actually a SERC done? Because, you know, you do understand this is not a SERC, what we're looking at right here.

A To my knowledge, there -- there was one that was done.

Q Oh, okay. All right. So, you agree that we're not looking at it right here, correct?

A This is a statement of estimated regulatory costs.

Q Right. This is an analysis to determine if a statement of estimated regulatory costs is required. So, is it your understanding there's a separate document that is the actual SERC that exists?

A I believe there is. Perhaps, I am confused.

Q Okay. And you mentioned something about there was an amended SERC as well. Did you say that?

MS. GALLAGHER: She did. I wrote it -- yeah.

THE WITNESS: Yes.

MS. GALLAGHER: Something -- something was amended.

THE WITNESS: I shouldn't say amended, but I -- well, again, I thought there was one done. I think the noticed correction that was done in May of this year was in relation to the SERC. So, maybe it's not necessarily amended, but just a correction that one was completed.

BY MS. HINSON:

Q Okay.

A I think initially there was notification that one went out, stating that one had not been completed when, in fact, it had.

Q Okay. That's helpful. Thank you.

A That is my understanding. I could be wrong.

Q Can you turn to Page 2 of the analysis.

A Yes.

Q Thank you. Now, "B" at the very top of the page -- that's "B" as in boy -- says, "The number of individuals and entities likely to be required to comply with the rule," and the response from the Agency says, "Only the medical services section will be required to comply."

I don't -- I don't understand that statement because, in my opinion, employers -- or excuse me -- carriers and healthcare providers have to comply with that rule. So, can you explain the statement, only the medical services section will be required to comply?

A I believe within 69L-31.016, there is a reference that the Division will provide or shall provide a determination in relation to the reimbursements of the MRAs, that's applicable to that service.

So, in that contents -- context, the Division would provide a finding. And that is not in relation to

a healthcare provider or a carrier.

Q Okay. Now, No. 2, under "B," says, "A general description of the types of individuals likely to be affected by the rule" -- and again, it refers to the medical section -- services section. And it says, "Only the medical services section will be required to comply." Now, I understand your explanation of No. 1, where it actually talks about, in that statement, comply with the rule.

No. 2 doesn't ask about compliance with the rule. What it asks about is the types of individuals likely to be affected by the rule. So, do you know why healthcare providers, or insurance carriers, for that matter -- but why healthcare providers aren't listed as an individual likely to be affected by the rule?

A Again, if you go back to .016, it talks about the Division providing a determination. That would be a requirement from the Division to provide. It's not a requirement to a healthcare provider or a carrier.

Q What's not a requirement?

A They're not responsible. The carriers and healthcare providers aren't responsible for evaluating and rendering a determination based upon a reimbursement dispute.

Q Correct. And I understand that as it relates

to your answer about statement No. 1 on this page.

Statement No. 2 reads differently. So, let's look at it again.

A Sure.

Q "A general description of the types of individuals likely to be affected by the rule" -- so, "affected" doesn't mean they have to comply with it. "Affected" means the rule is going to impact them one way or another.

So, do you not agree that healthcare providers and carriers are affected by that rule?

MR. NEMECEK: Form.

A I -- I don't believe that they are.

Q Why?

A Because a determination is still being provided.

Q A determination as to what?

A A determination based upon the applicable MRAs.

Q Okay. So, let's assume that that's correct and that's super helpful. Doesn't that affect a carrier and a healthcare provider?

MR. NEMECEK: Form.

A No, it's still providing a response.

Q How -- how does a response, even if it's a

positive, helpful response, not affect a healthcare provider?

MR. NEMECEK: Form.

A Again, I -- I don't think that it is because a response is generated. So, there is no adverse effect.

Q I'm not asking about adverse effects, and this doesn't even mention adverse effects.

A I -- I --

Q This mentions effect.

A I don't believe that it does.

Q Well, what's the purpose of you rendering the determination as to what's due and owing under the MRA?

A Can you repeat the question?

Q Sure. What is the purpose of you rendering what is due and owing under the MRA when you make these determinations?

A Okay. The medical service section -- I specifically don't render a determination, but the medical service section evaluates that reimbursement dispute. And they utilize the reimbursement manuals to outline what the reimbursement should be if there is an underpayment in relation to that dispute.

Q Okay. Earlier, you testified that when you make those determinations --

A Medical service does.

Q Right. And just for the sake of ease, when I say, you --

A Okay.

Q I know it's not you.

A Thank you.

Q So, we'll just assume it's the MSS. That's fine.

You testified earlier that when the MSS makes the determination under what's due and owing under the MRA, that it's to help the carrier and the healthcare provider work out their differences under the contract. I mean, I'm paraphrasing, but is that what you testified to earlier?

A Yes.

Q Okay. How does the fact that you intend for it to help them both not affect them?

A I -- I don't believe it does.

Q What is your definition of "affect"?

A I -- what is -- I -- I -- I would have to go to Webster dictionary to define that.

Q Okay. Well, I don't want to be contrary, but you're saying that the purpose of making this determination is to help the parties. So, you agree that it's to help the parties, but then, when I ask you is that not affecting them -- even if it's in a positive

way -- you're saying, no, it doesn't affect them.

A I think it's a -- it's a neutral situation. I do. I think it's a neutral situation. I -- I don't -- I don't think that it is a positive or a negative. I think it is an -- it's a neutral form.

Q But you said that the purpose --

MR. DOUGLAS: Objection. Asked and answered.

Q -- is to help.

MR. NEMECEK: Yeah. That's asked and answered.

MS. HINSON: Well, if it was answered, I wouldn't keep --

MR. DOUGLAS: Well, now it's just argument.

MS. HINSON: Yeah, if it was --

MR. DOUGLAS: It's just an argument, now.

MR. NEMECEK: Yeah --

MS. HINSON: If it was answered, I wouldn't keep asking.

MR. NEMECEK: Well, it's a legal argument at this point.

MS. HINSON: I'm not asking about substantially affected. I'm not asking about a legal term of art.

MR. NEMECEK: It's still part of substantially affected.

BY MS. HINSON:

Q Let's go to "D" on the bottom of Page 2. The question asks for a good-faith estimate of the transactional costs likely to be incurred by individuals and entities required to comply with requirements of the rule. And then it describes what transactional costs are.

Do you know why the Department stated that there were none; that the rule would only affect the Department?

A (Examining document.) Okay. What was your question, again?

Q Do you know why the Department checked the box "none" and stated that the rule would only affect the Department?

A In relation to the transitional costs?

Q Transactional costs, yes.

A Transactional costs. I specifically don't know.

Q Okay. Can you walk me through the current process for provider-carrier dispute resolution, the current process when there is a contract or a managed-care arrangement alleged?

And I'm talking about from the time that a healthcare provider submits the petition all the way

through the end. Can you just walk me through that process?

A Okay. And I'm going to state on record that I -- I specifically do not handle reimbursement disputes. That would have come from the medical service section.

So, starting from the process, when a medical dispute is received in, it is date-stamped. And then it is logged in. And then it would be assigned to one of the nurse case managers to address.

Specifically, your question with contracts or managed care, if there is a petition that is regarding a contract or managed care -- we have amended the form that goes out to both the carrier and the healthcare provider asking for additional information; who is the specific person that is responsible for overseeing that contract or managed care.

If they're -- and then, if there is documentation through the carrier response that there is a petition in place, then the Division makes a determination outlining the provisions of reimbursement based upon the MRAs of that particular service and does not address the contractual or managed-care arrangement.

Q Okay. And then you issue the determination. And then, let's say, for instance, that you find that

the carrier underpaid pursuant to the MRAs -- does that make sense to you so far?

A Yes.

Q If there wasn't a contracted or managed-care arrangement involved and you made that determination, the carrier, then, by statute -- and you can correct me if I'm wrong. It's my recollection -- then, by the statute, the carrier has 30 days to make payment to the healthcare provider; is that correct?

A I'm not -- I'm not sure about the time frame, the specific time frame of 30 days, but the determination does go out and outline the reimbursement that is the appropriate reimbursement as defined by whatever particular reimbursement manual.

Q Okay. So, there's -- at some point, that determination that the carrier underpaid does trigger an obligation by the carrier to, then, pay it or dispute it, right?

A Correct.

MR. DOUGLAS: Form objection.

Q If you make a determination when there's a managed-care arrangement in place under the MRA, and the carrier -- you find that the carrier didn't pay properly under the MRA, does the carrier, then -- if there's a managed-care arrangement or a reimbursement contract in

place, does the carrier, then, have that mandatory payment requirement where they either have to pay within "X" amount of time or they have to petition to DOAH?

A The -- the managed-care arrangement -- and it's a twofold. With the managed-care arrangement, the governing agency is the healthcare for -- the Agency for Healthcare Administration. So, as far as overseeing that managed care, I believe there are grievances in place within that system.

If there is a managed-care plan in place, we provide analysis of what the appropriate MRA would be, but we don't address the managed care because that falls under the Agency of Healthcare. And I believe that's in -- 440.0134 outlines the managed care. And I think that also falls under Chapter 641.

And I believe that the Agency for Healthcare not only authorizes the managed-care arrangements, but they examine and oversee those arrangements.

Q Okay. But --

MS. GALLAGHER: So, that's a no.

MS. HINSON: I think it is.

BY MS. HINSON:

Q But if there's a managed-care arrangement or a reimbursement contract in place and you say a carrier, you underpaid pursuant to the MRA, does that provision

in the statutes that says the carrier has "X" amount of time to either pay or to dispute it -- does that kick in when you make that determination that they underpaid on the MRA?

A Well, there's -- there's --

Q Yes or no, if you can.

A Actually, it is not a yes or no. And the reason behind that -- I know enough to -- a little -- a little frustrated. The reason behind that is because if it is a managed care that has been approved by the agency for AHCA, then, that has to fall within the grievance.

So, there is no disallowance or adjustment of the bill if there is a managed-care in place.

Q Right. So, your determination basically does nothing for the healthcare provider or the carrier.

MR. NEMECEK: Form.

MR. DOUGLAS: Form objection --

A It outlines what is applicable under the MRA.

THE COURT REPORTER: I'm sorry, sir. What was your objection?

MR. DOUGLAS: Form objection. Argumentative.

THE WITNESS: Can we take a five minute --

MS. HINSON: Absolutely.

(Brief recess.)

BY MS. HINSON:

Q Okay. Ms. Miller, we don't have much more.

A Is that a promise? For you.

MS. GALLAGHER: For her, yeah.

THE WITNESS: No, I'm just talking about her. I don't have much more.

(Laughter.)

BY MS. HINSON:

Q Okay. So, let's go back to the determination process. And I know there was a time frame when the Division did make determinations as to contracts or managed-care arrangements and whether or not reimbursement was proper under the terms of those agreements, correct?

A Yes.

Q Okay. What is the difference in the process that the MSS uses between when they did do it with the contracts in place and make those determinations under the terms of the contract versus now when they only make them under the MRA?

A I -- I don't know what -- what the guidelines that they used back when they did the petitions for the contract to managed care.

Q Okay. Because you weren't in your role?

A I wasn't in this role, yes.

Q At that point. Okay. That's fair.

A Thank you.

Q Are you going to be testifying at the final hearing in this matter?

A I don't believe that I am a witness. I -- I don't know. I -- I don't anticipate.

Q Your name was not on the witness list. I just --

A Okay.

Q It was sort of a pro forma question.

A No.

Q Not that you know of, is what your answer is, right?

A Not that I know of, yes.

MS. GALLAGHER: Not unless we call her.

MS. HINSON: True. True.

THE WITNESS: What was the date?

(Laughter.)

MS. HINSON: We're still working on that.

BY MS. HINSON:

Q Are there benefits to the state of Florida in having these reimbursement contracts or managed-care arrangements in place, that you know of?

MR. DOUGLAS: Form objection. Overbroad and ambiguous.

A What -- what --

MS. HINSON: Well -- hold on.

THE WITNESS: Okay.

MS. HINSON: I want an answer to this.

THE WITNESS: Can you re- --

MS. HINSON: And so --

THE WITNESS: Can you -- can you repeat the -- the question?

BY MS. HINSON:

Q I'm not sure how to say it any other way --

A Okay.

Q -- but yes. Do you know whether there are any benefits to the state of Florida in having managed-care arrangements and reimbursement contracts in place?

MR. DOUGLAS: Same objection. And I don't know if this is the proper witness to answer that.

MS. HINSON: Then -- okay. Then she can say that.

THE WITNESS: I -- I don't know. I don't know what that benefit would...

BY MS. HINSON:

Q Do you know whether it would impact the state if there were no privately-negotiated reimbursement contracts or managed-care arrangements?

A I -- I don't know.

MS. HINSON: Okay. As part of the responses -- the Division's responses to my discovery requests, they produced 45 pages of e-mails; although, it's my understanding there is more forthcoming. One of them is this one I'm going to hand to you.

Sorry, Tom. Did you want to look at this copy?

MR. NEMECEK: Oh, no. I just wanted to see --

MS. HINSON: Okay. Can we go off the record a second?

(Discussion off the record.)

BY MS. HINSON:

Q It's an e-mail dated October 3rd, 2016, from Charlene Miller to Andrew Sabolic. And in the text of that e-mail, you say, "Now, I'm stressed about Rule 69L-31." Do you know what you were stressed about?

A Yes.

Q Okay. What was it?

A It was -- this was my first time at doing the edification of 69L-31 and submitting it downtown to legal. And if you go up to subject, "Third time." So, this was my third time of sending it to Mr. Sabolic, and he and Mr. Hershel reviewing it to make sure I had captured all of the edification.

Q Okay.

MS. GALLAGHER: What was the date of the e-mail? I'm sorry.

MS. HINSON: Here, you can take a look. I'm the going to attach it as well, but --

MR. NEMECEK: Okay.

MS. HINSON: October 3rd, 2016.

Okay. Those are all of my questions.

EXAMINATION

MS. GALLAGHER: Okay. As you know, I represent the Florida Society of Ambulatory Surgery Centers. And I'd say the same thing that Jennifer said at the beginning; that if you don't understand my questions, please ask me to rephrase them or tell me you don't understand it and we'll see if we can clarify.

Let's -- do you have a copy -- oh. Stop. Let's go off the record for a second.

(Discussion off the record.)

BY MS. GALLAGHER:

Q We're going back to the beginning on some preliminary questions. Back on the record.

You indicated you've been in your current position for about a year. Do you hold any particular licenses or certifications?

A No.

Q Okay. Ms. Hinson asked you about carriers being penalized or providers being -- being penalized, particularly with respect to carriers and looking and finding a pattern of practice for poor payment.

Are you aware of any sanctions taken against carriers for a pattern and practice of deficient payment within the last two years?

A No.

Q Okay.

A But again, I -- I'm not the appropriate person.

Q Right. Okay.

Now, did I understand you to say that you oversaw the team that reviews -- or that handles the dispute-resolution process -- or the reimbursement-dispute process?

A Yes.

Q Okay. And who are -- who are on -- who is on that team?

A In the medical service section?

Q Uh-huh.

A There are four nurses. We have four clerical support and two medical healthcare program analysts and one current vacant position -- so, a total of three --

and then one supervisor and then one senior management -- I don't -- I forget the rest of her title, senior management program supervisor.

Q Who would that be?

A Theresa Pugh.

Q Okay. Of the nurses -- are any of the nurses certified medical coders?

A I have no idea.

Q And what is a medical healthcare analyst?

A What are they?

Q What do they do?

A They handle questions that come in from healthcare providers and carriers. They review analysis to try to determine trends and bring those to senior management's attention.

Q What are the qualifications those people have for those positions? Do -- if you know.

A I don't specifically know their qualifications. We do ask that they have a college education or years of experience. But specifically to those individuals, I have no idea what --

Q As far as you know, they're not licensed nurses or any other type of healthcare provider?

A I'm not aware.

Q All right. Are there any positions that

you're aware of on the dispute -- or the reimbursement-dispute team that involved people or -- start over again. Just strike all that.

Are there any people on the team that are certified medical coders?

MR. DOUGLAS: Asked and answered.

MS. GALLAGHER: No, I asked her about the nurses. I just now --

THE WITNESS: I --

MS. GALLAGHER: -- am broadening.

MR. DOUGLAS: Objection.

THE WITNESS: I believe -- I believe there is, but for medical billing.

BY MS. GALLAGHER:

Q But do you know who?

A The one that I know of specifically is -- first name is Valeria -- I'm not sure of her last name, but she --

MS. ROSEN: Williams.

THE WITNESS: Williams? Thank you, from the voice in the corner.

BY MS. GALLAGHER:

Q What is her position?

A She is a healthcare program analyst.

Q One of those?

A Yes.

Q Your under- -- or your belief is she's a certified coder?

A It is my understanding that she did --

Q Okay.

A -- take those examinations, yes.

Q Okay. You were asked a question regarding this report to the three-member panel for Fiscal Year 2015 regarding what managed care meant on Page 5 as a reason for dismissal. There was a lot of discussion about that.

Is it simply that there was a managed-care arrangement alleged to be in place or in place, and that was the reason for dismissal? Is that what managed care means?

A It -- it's possible.

Q But you really don't know.

A No.

Q Okay. You also stated in response to that line of questioning that when there was evidence of a managed-care arrangement, that that resulted in dismissal of the petition.

And I was -- my question is: What is the evidence of a managed-care arrangement? What constitutes evidence?

A In relation to Page 5 of 5?

Q No, just in -- generally, what constitutes evidence of a managed-care arrangement when a -- in a resolution -- or in a reimbursement dispute?

A Okay. Can you re- -- repeat that question again, please?

Q In a re- -- just more of a general question.

A Okay.

Q In a reimbursement dispute, under the process that we're here, 440.13(7), what evidence -- what constitutes evidence of a managed-care arrangement between the parties?

A It can be documentation provided by both the healthcare provider and/or the insurance entity.

Q For the carrier, can it only be information provided in the carrier response that they're required to submit?

A That is my understanding.

Q All right. So, a copy of an EOB provided with a petition from a provider that mentions as a reason of non-payment, you know, outside a contract or outside managed-care arrangement -- you don't consider that to be evidence of a managed-care arrangement.

A No.

Q Okay. Just wanted to be clear.

You were also asked questions about of the re- -- of the petitions for the reimbursement -- regarding reimbursement disputes that go all the way through the process to determination, that 85 percent -- 85.5 percent of those resulted in an underpayment by the carrier. And that's referenced, again, on Page 5 of that report.

Do you know whether any specific analysis was undertaken to determine why more than three-quarters of the disputes that go all the way to determination and come before the Department are -- are resolved in favor of the provider?

A I'm -- I'm not aware.

Q Okay. Does the Division publicize the number of sanctions or the penalties it imposes against carriers, for whatever reason they are penalized?

A I'm not sure.

Q Do you know if that's a matter of public record?

A I'm not sure about that either.

Q Okay. And what about penalties imposed against providers? Same question: Do you publicize that?

A I'm not -- I'm not aware.

Q And you don't know if it's public record?

A I -- I don't.

Q Okay. When the decision was made to implement the policy -- the new policy in the rule and stop providing a determination whether there's been an improper adjustment or disallowance when a managed-care arrangement is in place or a contract is in place -- I believe you said you weren't involved in that decision, but do you know who was?

A It was my understanding that there was communication between the Division and downtown legal from the -- and when I say that, that would be the Department of Financial Services' legal team.

Q You don't know who -- who the parties were to that communication?

A No, I don't.

Q Okay. You indicated you thought that the medical services team did not render decisions on manage- -- involving -- determinations -- and when I say determinations, I'm talking about reimbursement-dispute determinations -- on managed-care arrangements until October of 2014. And I'm wondering, if that's true, who handled them before then?

A I -- I have no idea.

Q Okay. And once you -- once the Division started handling them and issuing a written

determination including whether there was an overpayment or improper -- underpayment or improper adjustment or disallowance, who handled those? Was that the medical services team?

A The reimbursement disputes?

Q Uh-huh.

A Yes.

Q All right. And how did they manage to do that if, now, for some reason, they -- they're not able to do that?

MR. NEMECEK: Form.

A I wasn't around in -- in 2014 when they started. So, I -- I'm not sure of the specifications of what they were looking at to make those determinations.

Q Okay. Legal downtown refers to the -- like you said, the Department of Financial Services' legal team and their offices downtown?

A Yes.

Q Okay. All right. Does it involve anybody at the Governor's office?

A I'm -- I'm not sure.

Q Okay. Do you know what the -- let me back up.

Do you know what the concerns were during the discussions, I think you said earlier, between Andrew, Tanner, Pam, and the legal department downtown about

making determinations of an overpayment -- or not overpayment -- an improper disallowance or adjustment when there was a managed-care arrangement, such that they proposed this rule where they would no longer do that?

A It -- it is my understanding that, based upon the discussions that they had with the legal department regarding contracts and managed care, that the Division didn't have the necessary statutory authority to decide contractual disputes or managed-care disputes.

Q So, the basis for this rule, as you understand it, is that the Department contends it doesn't have authority to resolve disputes when there is a managed-care arrangement or a contract in place?

A Specifically contract disputes? Yes.

Q Okay. So, they were acting without statutory authority the years that they did resolve such disputes?

A I'm not sure if that -- I'm not sure about that, but there was -- there was questions and concerns regarding that. Whether that's applicable, I have no idea.

Q Okay. So, as far as you know, there wasn't a concern about the -- about a lack of expertise to resolve disputes where there was a managed-care arrangement or contract?

A I -- I don't know.

Q You haven't heard that discussed, that we don't have the expertise for this, or anything like that?

A I'm not aware that that was one of the generating factors.

Q Okay. So, the Department was simply -- in proposing this new rule, the Department is simply trying to get out of the business of acting beyond its statutory authority; is that your understanding?

A I -- I would say it -- it's that and -- and trying to facilitate a self-execution -- self-executing system.

Q I was going to ask you about that. That was the very next line in my notes. What exactly does that mean, facilitate a self-executing system? What is a self-executing system?

A Well, I believe that is terminology that not only is the Division's, but all that I have seen in some of the comments that have come in from all parties of which you represent.

The Division, as a facilitator -- we try to provide guidance in having the two parties, whether it's a healthcare provider or the insurance entity, working together to provide -- the job is to provide appropriate

medical treatment to the injured worker. And that includes everybody working together, the self-executing process, and making sure it's -- it's smooth and seamless for everybody involved.

Q So, how does excluding two categories of reimbursement disputes -- i.e., those with contracts or managed-care arrangements -- help streamline the process or help the -- help to facilitate a self-executing system?

A Well --

MR. NEMECEK: Form.

Go ahead.

THE WITNESS: Did you hear him? Sorry.

It's not excluding --

MS. GALLAGHER: Okay. Yeah. Okay. Yeah, what -- yeah, what form?

MR. NEMECEK: You're saying excluding. I think it's a bit vague. They're still going to enter a determination.

MS. GALLAGHER: Well, actually, they're not. They're -- it's a neutral determination, as you said in your response to discovery.

BY MS. GALLAGHER:

Q But anyway, you can go -- you can answer the question. We obviously view the rule differently. We

see it as excluding from the statutory obligation to resolve the dispute, give the parties a resolution; that the -- the new rule excludes two categories: those where a contract is alleged or exists or those where a managed-care arrangement is alleged to exist or exists.

So, how does excluding those -- those types of disputes from getting a resolution -- how does that facilitate a self-executing system?

A Well, again your assessment would be excluding, but the Division's assessment is that it doesn't exclude. That healthcare provider still has a right to submit in a reimbursement dispute.

But specifically in relation to the contractual agreement that they have with that particular insurance entity, we don't render a decision based upon contractual language. We're not privileged to that, but we do provide the reimbursement based upon the reimbursement manuals.

Q Okay. The reimbursement manuals, which are a matter of public record, correct?

A Correct.

Q So, how does telling people what they already know from a public record, basically what the RMA [sic] is, help facilitate a resolution of their dispute?

MR. DOUGLAS: Form objection. Overbroad

speculative. Lack of predicate. Fails to ignore all the other issues in the reimbursement dispute determination, simply overbroad.

Q You can answer the question.

A Just because it's available doesn't necessarily mean that people choose to abide by the reimbursement manuals.

I -- I think the Department is required to outline for that healthcare provider as well as the carrier of what the expectation is as it relates to that particular treatment and the reimbursement that's allowed for that.

Q Right. But that's a matter of public record, correct?

A Sure.

Q So, either party can look that up and read that for themselves.

A If they choose.

Q Right. And if they have a dispute and they can't agree, that's when they come to the Department, right?

A Yes.

Q So, they would be looking for something more from the Department, other than what is already available in the public record, correct?

MR. DOUGLAS: Speculative, asks her to go into the mind of the third parties.

Q You can answer the question.

A Well, I'm not sure what they would be looking for, but we do provide an -- an assessment of what would be due.

Q Okay. Do you agree -- do you contend that those assessments of what would be due under the RMA [sic] provide either party with an enforceable order?

MR. NEMECEK: Form.

A No.

Q So, it doesn't give them an enforceable order.

A In -- in relation to a contract or managed care?

Q Well, in order -- in regards to a resolution of their dispute; that it would either trigger the obligation of the carrier to pay or would allow either party to appeal to the Division of Administrative Hearings.

MR. DOUGLAS: Can you re-ask that, the second part?

MS. GALLAGHER: Just read it back, please.

MS. HINSON: Can you read it back?

(Question read back.)

(Discussion off the record.)

MR. DOUGLAS: Objection. Those are two separate questions.

MS. GALLAGHER: No, it's describing what an enforceable order is.

BY MS. GALLAGHER:

Q So, you can -- you can go ahead and answer it.

A I -- if -- if the -- if there is a determination made and it is outlined and it does not entail a contract or a managed-care arrangement, then the notification is sent to all parties involved and both parties can appeal that.

If there a contract in place, that's a contractual dispute. And we -- and the Division provides an assessment of what would be due or owing based upon the MRA, but does not get into the contractual disputes.

Q Okay. And what can the parties do with a -- a determination -- and I use that word sort of facetiously -- from the Department of what is allowed under the RMA [sic] -- which they could read on their own -- what -- what do the parties do with that determination?

A Whatever they choose to do.

Q Okay. So, how has the Department -- how has the Department satisfied its obligation to resolve the

dispute between the parties? Which is what the statute says you'll do.

A Right, but that it's a contract dispute and not a reimbursement dispute, which is what is required by the Division to resolve a reimbursement dispute. That dispute is related to a contract.

Q Oh, okay. So, now, the -- so, now, the theory or the claim is that it's not a reimbursement dispute under 440.13(7); it's a contract dispute.

MR. NEMECEK: Form.

A That's my --

Q When there's -- when there's a contract or a managed-care --

A That's --

Q -- arrangement?

A That actually is my assessment, but as well as -- Parallon's notification that they sent in, they cond- -- they also called it a contractual dispute in the letter that they -- that he submitted to the Division.

Q So, is that what determines what -- what these dispute-resolution petitions for everybody else are; if there's a contract or a managed-care arrangement, the fact that one provider referred to it as a contract dispute?

A No. No, I'm not saying that as all.

Q Okay. So, you do contend that the Department -- you believe -- you contend that the Department is following the manual, the reimbursement manual, when it issues these determinations about what's in the RMA [sic]?

A Yes.

Q And you say that you don't have any authority to look at a -- at the contract -- what an agreed contract price would be --

A Yes.

Q -- correct? Okay.

Let me look -- direct you to the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers. And I guess it's been codified in Rule 69L-7.100, Florida Administrative Code. This is the two -- it says it's the 2015 edition, but it's effective January 1st, 2016. And -- can I have your page?

I want you to look at Page 17 where it talks about reimbursement for surgical services.

A (Examining document.)

Q Okay. And I'm looking at the portion that says: For each billed CPT code not listed in Chapter 6 of this manual, the ASC shall be reimbursed 60 percent

of the AC's billed charge or the agreed-upon contract price. Do you see that language?

A Uh-huh.

Q Okay. Now, doesn't that suggest to you that the Department, in it -- when it's talking in its manual that there's an agreed -- that there can be an agreed-upon contract price; that it, then, can look at the agreed-upon contract price to see if -- if that's been paid or the 60 percent has been paid when there's a reimbursement dispute?

THE WITNESS: (Examining document.)

Can you read back her question, please? Thank you.

(Question read back.)

THE WITNESS: Yes, the Department can look at the contract price.

BY MS. GALLAGHER:

Q Okay. So, the notion that the Department has no authority to look in a reimbursement dispute, i.e., those instances where the parties could not resolve their dispute between themselves and, so, they brought it to the Department under the statutory procedure -- so, in those instances, the Department can look at whether they're being paid -- when there's a contract or in a managed-care arrangement, they can look at the

agreed price in the contract and see whether that's been paid.

MR. DOUGLAS: Form objection.

A They can recognize it. Whether or not that contract is being applied appropriately, I don't think that the Division can.

Q Okay. So, when the ASC is entitled to be paid either the 60 percent of the surgical fee or the agreed contract price, you're saying that the Department can't look at -- in determining the reimbursement dispute, can't look at either -- they can't look at both of those things, if there's a contract.

A I'm not -- I'm not saying that. They -- they can -- they can recognize that the either/or is applicable. But as far as the contract rate, I -- I don't believe that they -- the Division has the authority to ascertain if that rate is appropriate or being applied.

Q Well, not necessarily whether it's appropriate. It just says the agreed-upon rate. But if it's not being -- I mean, you certainly could determine from the petition and the paperwork submitted whether the agreed contract price had been paid or not. And presumably, they provide you the agreed contract price and, then, what has been paid so you could determine

that.

I mean, that's what the Department has been doing since -- you know, until they implemented this new policy.

MR. DOUGLAS: Form objection. Argumentative and compound.

A Actually, with -- without all the documentations of that contract, there's no way of knowing the Division -- there's no way for the Division to know that that amount specified is appropriate.

Q Well, it's not appropriate. The -- the manual refers to the agreed-upon price. So, it's not up to you to decide -- if they agreed for 20 percent of what's in the RMA [sic], it's not up for you to decide whether that's appropriate.

My question is that, if the petition -- if the petitioner gives you a copy of the contract that states what the agreed contract price is, you know, under the manual, aren't you allowed to determine -- I mean, you can do the math and determine whether the agreed contract price has been paid if you're given the documentation for that.

MR. DOUGLAS: Form objection. Argumentative. Lack of predicate, in terms of lack of all the terms and conditions of the contract to be

reviewed.

A I -- I don't believe it's that simple. I -- I think you would need all of the terms of the contract to -- to ascertain if that -- if that contract amount is applicable.

Q Okay. So, that -- but presumably, then, the Department had all the necessary information for all the time that it was making these kinds of determinations --

MR. NEMECEK: Form.

Q -- when there was a managed-care arrangement or contract.

A I have no idea.

Q Okay. You do recognize, don't you, that the statute requires the Department to -- let's get the right example.

You do recognize that the statute requires the Department to provide the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed the payment, correct? I'm looking at 440.13(7)(c) --

A Yes.

Q -- Florida Statutes.

Okay. All right. So, telling a party -- let me back up. Where does it say in that statute that you won't do that for situations involving a contract or a

managed-care arrangement between the parties? Where does that statute say that?

MR. DOUGLAS: Just that subsection or the entire --

MS. GALLAGHER: Just that -- just that section.

MR. DOUGLAS: Okay.

THE WITNESS: Well, I would refer you to the second part of Paragraph C where it says, "The Department must be guided by standards and policies set forth in this chapter."

BY MS. GALLAGHER:

Q Right. That's how you go about rendering your determination. I'm saying, where does it say in Subsection C that the Department will not provide a written determination of whether the carrier properly adjusted or disallowed payment when there is a contract or managed-care arrangement alleged or in existence?

A Well, the Department is providing a written determination. And it's based upon the MRAs, which happen to be the standards and policies that are guided within the chapter.

Q No.

A Yes.

Q A written determination -- the Department, by

providing a statement of what's in the public record, the RMA [sic] -- how does that provide a determination of whether the carrier properly adjusted or disallowed payment?

A It's utilizing the standards and policies that are set forth.

Q No. Where is the determination -- if you say, well, you're entitled to -- this is what's allowed under the -- under the R- --

MS. HINSON: MRA.

MS. GALLAGHER: The MRA -- thank you. RMA -- have I been saying RMA?

MS. HINSON: Uh-huh.

MS. GALLAGHER: MRA.

BY MS. GALLAGHER:

Q Where does that say that whether -- and therefore, the carrier properly adjusted or didn't properly adjust or properly disallowed or didn't properly disallow?

When you say, this is what's under the MRA, where is the sentence that says, therefore, there's been -- there's been no prop- -- no improper disallowance or adjustment?

MR. DOUGLAS: Form objection.

MR. NEMECEK: Form.

MR. DOUGLAS: Incomplete hypothetical and lack of predicate.

MS. GALLAGHER: Okay.

THE WITNESS: Well, again, with -- within regards to the Division feels that it is providing a written documentation, it is utilizing the standards and policies set forth in the chapter. And nowhere in this chapter is there standards and protocols in place for the governance of a contractual or managed-care agreement.

BY MS. GALLAGHER:

Q Well, it's in your manual. You recognize that in your reimbursement manual.

A But specifically --

Q Let me back up. I want to stay on my question.

A Sure.

Q How are you -- when you tell somebody what's in the public record about the MRA, how does that tell each party who's right, who's in -- each party in the dispute who's in the right and who's in the wrong?

A In relation to a contract?

Q Yeah, that's what we're talking about.

A Okay.

Q When there's a contract -- when there's a

contract -- under the proposed rule, when there's a contract and managed-care arrangement, and all the Department is going to do is say, this is what's permitted under the MRA -- how does that tell the parties, the affected parties, who's in the right and who's in the wrong? Because after all, this is a dispute they could not resolve themselves. So, they came to the Department for resolution.

So, how does telling them that tell who was right and who was wrong?

MR. DOUGLAS: Form objection. Incomplete.

MR. NEMECEK: Form.

THE WITNESS: Did you get that?

Well, it outlines -- it outlines for both parties what the standard would be. As far as who's wrong and right, it doesn't address that. It simply provides the reimbursement that would be allowed under that MRA.

BY MS. GALLAGHER:

Q So, it really gives them no determination to resolve the dispute.

A The contract dispute.

Q Right. You said, go back and do it on your own. I think you said that earlier, they're supposed to go back and do it on their own?

A I don't recall saying that.

Q Okay. Well, what are they supposed to do when they've come to the Department under the dispute-resolution procedure for the Department to resolve a dispute, and all they get from the Department is a recitation of what the MRA says, which they could all read by -- for themselves before they filed the petition? What does that do for them?

MR. NEMECEK: Form.

Q How does that resolve the dispute?

MR. NEMECEK: Form.

Q Or does it?

A I -- I would have no idea of how they're going to utilize that to help resolve their dispute.

Q Yeah, but isn't it the Department's job under that statute to resolve the dispute? I mean, it's called Utilization and Reimbursement Disputes.

A Reimbursement --

Q Right.

A Reimbursement disputes.

Q Reimbursement disputes.

A Right.

Q So, how does that resolve the reimbursement dispute when you say, I don't know how they're going to use that statement, but -- so, you haven't resolved it,

then. There's something else that they need to go do.

A But we are providing them with the standard and -- and policies and protocols that is governed regarding that -- that procedure.

Q Right. But that's all stuff they know. And they -- you know, anybody can look at the public record. How does telling them that resolve the dispute one way or the other?

MR. NEMECEK: Form and asked and answered.

MR. DOUGLAS: Asked and answered and --

Q Or does it?

A I think it provides them with the documentation. Regarding the outlines of the contract -- how they choose to utilize that is up to them.

Q So, it doesn't resolve the dispute.

A I think we provide them with documentation that they can utilize.

Q To resolve their own dispute.

A That contractual dispute.

Q Okay. So -- so, in other words, the Department is not providing a determination of whether the carrier properly adjusted or disallowed payment. You're only giving them guidance so that they can use it to resolve their contractual dispute, correct?

A No, it is a determination and it does outline the standards and --

Q No. No. No.

A -- protocols.

Q I'm going to interrupt you.

A Sure.

Q The determination of whether the carrier properly adjusted or disallowed -- it's a determination of what's in the MRA, but it's not a determination of whether the carrier properly adjusted or disallowed. You've said that. It's just to give them -- it's giving them guidance as to what the standard is on the MRA.

And how they choose to use it is up to them, but basically, how they choose to use it to, then, go try to resolve their own dispute, under their own contract --

MR. DOUGLAS: Objection.

Q -- correct?

MR. DOUGLAS: Argument.

MR. NEMECEK: Form.

MR. DOUGLAS: And --

A Again, I'm going to go back to my standard answer. We do provide a determination. It is specific to the standards and policies that are set forth in the chapter.

Q But is it a determination that tells the affected parties whether the carrier properly adjusted or disallowed payment? That's a yes-or-no answer.

MR. DOUGLAS: Calls for a legal question at this point.

MR. NEMECEK: Yeah.

THE WITNESS: Yeah, I --

MS. GALLAGHER: No, it's not. It's a yes-or-no answer.

THE WITNESS: It -- I can't answer that because it requires a le- -- yeah, that requires a legal opinion on whether or not that contract is valid and whether or not the terms are applied.

BY MS. GALLAGHER:

Q No, it doesn't.

A Sure it does.

MS. GALLAGHER: Let me get -- can you pull out that sample that -- that was on our petition?

MS. HINSON: I've got them marked for you.

MS. GALLAGHER: Yeah.

MS. HINSON: This is the old way. This is the new way.

MS. GALLAGHER: Okay. Thank you.

I'm sorry.

MS. ROSEN: That's okay. I have it.

BY MS. GALLAGHER:

Q Okay. Well, let me ask you this: Are you aware that the Department has said that it doesn't -- the determinations -- and I put that in quotes -- that it renders in accordance with the proposed rule when there's a contract or managed-care arrangement do not provide a resolution to the parties that's favorable to one party or the other? Are you aware that the Department has said that?

MR. DOUGLAS: Form objection.

Do you have that documentation for her?

MS. GALLAGHER: Well, it's an answer to interrogatories. I mean, it's -- you know --

MR. DOUGLAS: Okay. I didn't know where it came from.

MS. GALLAGHER: Yeah, it's their answers to interrogatories and maybe requests for admissions, but -- so --

THE WITNESS: Could I review that? Do you have a copy of that?

MS. GALLAGHER: No.

MS. HINSON: What is she looking for?

MS. GALLAGHER: She's looking for their response to our request for admissions.

Actually, I might --

MS. HINSON: I don't have yours.

MS. GALLAGHER: Actually, I might -- let's go off the record.

(Discussion off the record.)

(Brief recess.)

MS. GALLAGHER: Can you read back my last question?

(Question read back.)

THE WITNESS: Yes.

BY MS. GALLAGHER:

Q You are now. Okay.

What's the difference, in your mind, between a situation where in -- in a resolution dispute that's before the Department, where a contract or managed-care arrangement is alleged to exist as opposed to actually exist?

MR. DOUGLAS: Is there a question?

MS. GALLAGHER: Well, I'm wondering why the Department made that distinction because there either is or isn't a contract or a managed-care arrangement. And so -- but yet, the rule covers situations when it's only alleged.

And so, if the Department -- so, I'm trying to say, what is the difference because, if the Department doesn't know whether there really is a

contract or managed-care arrangement -- it's only alleged -- couldn't it be true that there is no contract or managed-care arrangement and, therefore, the dispute should be treated in the -- resolved in the normal way or the usual way.

MR. DOUGLAS: Is -- can I interject? Is that meant to be alleged by both parties? Because that's what we see --

MS. GALLAGHER: I'm just -- the rule --

MR. DOUGLAS: -- the parties --

MS. GALLAGHER: But the rule doesn't say.

MR. DOUGLAS: Oh.

MS. GALLAGHER: The rule just says it's alleged -- let's look at the exhibits.

MS. ROSEN: I think either party alleges.

MS. GALLAGHER: Yeah, either party can allege it, but -- the rule simply talks about --

MS. ROSEN: Or asserts -- either party asserts.

MR. NEMECEK: I just want to put on the record that Andrew Sabolic may be a witness who is better situated to answer this kind of question.

MS. GALLAGHER: Right.

MR. DOUGLAS: He's the one you actually listed as the witness?

MR. NEMECEK: Yeah.

MS. GALLAGHER: Well, she supervises the -- the team that resolves disputes.

BY MS. GALLAGHER:

Q And so, I'm -- the rule provides -- the proposed rule -- when either the healthcare provider or carrier asserts that a contract between them establishes the amount of reimbursement to the provider or where the carrier provided healthcare services to the worker through a Workers' Compensation managed-care arrangement -- I guess my question is: What -- does the Department, then, have to satisfy itself that there actually is a contract or a managed-care arrangement in order to act under the new rule, in accordance with the new rule, and just do the determination of what the MRA is?

A Does the Department have to act on whether it certifies?

Q Let me -- my question is: If somebody just asserts it, is that enough for the Department to say, okay, there's a managed-care arrangement or contract. So, we're not -- we're just going to tell you what's in the MRA? Or does the Department have to verify in order to go forward under this new policy, like, get the documentation; say, show us the contract or the MCA?

A Well, the Division is asking for the person that is responsible for that contract. So, it's not -- so, asserting means that -- and I believe that it's also a requirement of the reimbursement is that you -- that the petitioner, as well as the carrier, provide all of the appropriate documentation to support the dispute.

(Discussion off the record.)

MS. GALLAGHER: Could you read me back her answer, again?

(Answer read back.)

BY MS. GALLAGHER:

Q Okay. But have you -- are you aware of the changes to the petition form requirements under 69L-31.005; how they've revised -- how they're revising the form?

A Do you have a copy of the form to review?

Q No, because it's a link. It's just on a portal.

A Because it does ask for -- for the person that is responsible for the contract.

MS. GALLAGHER: Hold on for a second.

(Discussion off the record.)

BY MS. GALLAGHER:

Q Well, we'll -- I mean, if the form no longer allows for submission of contracts or the MCA -- or

evidence of the MCA -- would that, then, give the Department -- that's an if -- would that, then, give the Department the information it needs to confirm whether there really is a contact or MCA?

A Well, the form has been actually revised. And it does require the name of the person that oversees that contract.

Q Okay. And so, it's your testimony, then, that by getting the name of the person that oversees the contract, the team reviewing the dispute is going to contact that person and determine whether there really is a contract?

A No, the team is not going to contact. First of all, that -- if you go back to -- and I -- and I want to -- because I had said this before and I think she said no. In 69L-31.005, Subsection 2, it says, the petitioner must submit the petition forms and all documentation supporting.

And I had said that was applicable to both the carrier and the healthcare provider. And then somebody said, no, that wasn't applicable anymore. It still is applicable. If -- if there is an alleged contract, it's not just a simply check in the box, I think, which was on Question 5 of the form before, but now they are required to provide detail.

The reasoning behind that is, if -- if there is allegations from both sides, the healthcare provider says that there's no contract in place, and the carrier says, and there's no documentation to support that a contract exists, then, the Department can render a decision based upon the appropriate MRAs that govern that decision because there is nothing to support that a contract existed.

So, alleging means that you have to support that with the documentation; not just simply checking the "yes" box, which is, I believe, what you were referring to in the form prior.

Q What I was -- yeah, I think what we're saying is that the form is being amended to eliminate that box and -- and eliminate the opportunity to provide the evidence of the contract.

And I was saying, if that's true or if that's accurate, would that, then, allow the Department the information it needs to confirm the existence of a contract or an MCA?

A It -- it's not true.

MR. DOUGLAS: Asked and answered.

Q Okay. It's not true.

A It's not true.

Q Well, we'll -- we'll see if we can get access

to the portal and find out because, for some reason, we thought that was true. That's why we put it in our petition. That's the other section of the rule that we're challenging.

A Can I just go on record to say that we're asking for more information beyond just the check box on the -- on the prior form.

Q Well -- that's fine. I think you said that, but -- so, what's the purpose of having the identity of the person who is in charge of overseeing the contract, if you're not going to contact that person?

A Well, if there -- if -- if either -- if either party is alleging that there is a contract, there has to be somebody that oversees that contract. So, again, going back to having both sides provide the evidence to support the allegations on either side, whether it's a contract or not a contract.

Q But if nobody -- if there's an allegation that there's a contract by one of the parties, and they list the name of a person that oversees contract, but they don't give you a copy of the contract to prove that there really is a contract, you're not -- and you're not going to contact that person, what's the purpose of having the identity of that person on the form?

A Well, I think it provides the Division with

data to ascertain whether or not contract language is being appropriately applied in reimbursement disputes. And if there is a situation where we have that information, and there is a trend with either the healthcare provider or the carrier, under 440.13(11), it allows the Division to go in and audit.

Q I agree that's what that statute says. My question has to do with the amended form and the -- the additional information you're talking about, the Department requiring, i.e., the name of the person in charge of the contract.

And I'm saying: What's the purpose of having that person's name, if you're never going to contact that person?

A Well, again, we can utilize that information to see if there -- if -- if people are repeatedly -- if both the healthcare provider or the insurance carrier is alleging a contract is in place and there isn't -- if that pattern continues, that does allow the Division to go through the front door of either the healthcare provider and/or the carrier and audit.

And if audit determines that there is inappropriate billing or a disallowance that's being applied inappropriately for that particular -- whoever it would be -- that allows the Division to assess

penalties and fines.

So, the whole point is, is to obtain that information to see if -- to see if there are people that are abusing that privilege of asserting a contract or managed care that's in place. And there isn't.

Q Okay. So, your -- your testimony is that, unless the provider -- unless the person or the entity asserting existence of a contact or MCA really gives you a copy of it, you're not -- the Department is not going to -- not going to determine that there is a contract and then follow the new rule. It will treat it like there's no contract or MCA.

MR. NEMECEK: Form.

A Make -- I just wanted to make sure I understand.

Q I mean, if you never get -- if you don't have a copy of a contract or an MCA arrangement when somebody -- when one of the parties asserted it, you know, the carrier files their response, provider, vice versa, you're not going to treat it as if there were one, unless -- if you don't have one.

A If there's no documentation to support it.

Q Okay. The mere identify- -- the mere act of identifying someone they claim to be is in charge of a contract is not sufficient to prove the existence of the

contract, correct?

A Corr- -- correct.

Q Okay. That's --

A All documentation. Yeah.

Q That's what I was getting at.

A All documentation.

Q Okay. And what you were getting at is, if you have some carrier, you know, 50 times lists Jane Doe as in charge of the contract and never provides a contract to the Division, you may go in and audit them.

A That provides us with data, yes.

Q Right. Okay. Is it your understanding -- and again, you may not be the right person -- that the documents that are entitled "Department of Financial Services Analysis to Determine if a Statement of Estimated Regulatory Costs is Required" is the actual SERC? Or do you know?

This is Form DFS EO 2163. Do you know if that is the actual statement of estimated regulatory costs? Or is that what it says it is; an analysis to determine whether you need to do a statement of estimated regulatory costs?

A I -- I would -- I would have to actually double-check on that and make sure that that is -- I know that one was looked at. And the statement of

estimated regulatory -- I -- I would believe that would be the acronym for SERC, but --

Q It is.

A Yeah.

Q But you referenced having seen SERCs. And I'm just asking you if those are the documents you were referring to as the SERCs or was there some other document?

A This probably --

Q If you recall.

A -- could be it. I'm not sure, but it probably could be.

Q Okay. You -- I think I gave you two.

Now, you came into this in June -- into this position in June of 2016. So, were you involved at all in the preparation of the Form 2163, the Department of Financial Services Analysis to Determine if a statement of estimated regulatory cost is required?

A I -- I was.

Q Do you know which parts you would have been involved in?

A Towards the end -- initially it -- when the SERCs were completed and the MRA was done, I believe that the legal department, in their original notice, said that a SERC was not completed, but -- when, in

fact, it was.

And I'm not sure of the time frame, but I got involved with the attorney that -- that oversaw -- Paul, who oversaw the workshops and the hearing, as well as with Theresa Pugh, David Hershel, and Mr. Sabolic.

Q So, with regard to the form you just reviewed, you don't know specifically a section that you would have been involved in in answering the questions that are in it?

A Initially, I was not involved in that. I did get -- we did come into play when there was a -- when we were aware of the fact that the notice had gone out that there was not one completed.

Q Okay. So, do you know which sections you might have worked on in this form?

A No, I don't.

Q Okay. That's fine. That's all the question was.

Are there any lawyers that are -- for the Department that are assigned to the medical services unit or the team that resolves dis- -- or handles the dispute -- or the reimbursement disputes? Do you have a regularly-assigned DFS attorney to assist you or provide guidance to you?

A Well, I don't know if he was technically

assigned to us, but David Hershel did work with the medical service section until his retirement. And then, currently, Tom is working with us. Now, specifically whether they are assigned, I -- I don't have any idea, but they do work with us.

Q But Tom is your go-to guy when you have a question on a reimbursement dispute?

A Unfortunately, probably, for him, yes. Him and -- well, all the attorneys that are available on the third floor to assist us, but -- but Tom, we do -- we do tap Tom.

MS. GALLAGHER: Okay. I think that's all I have for her.

THE WITNESS: Right.

MS. HINSON: I think --

THE WITNESS: I'm going --

MS. GALLAGHER: Thank you. She may have --

THE WITNESS: I'm going to take a five. I've got to go up- -- I'm going to see if we can get a fan because I'm starting to get a headache from the heat, so --

MS. HINSON: Okay.

MS. GALLAGHER: Okay.

(Discussion off the record.)

(Brief recess.)

MS. HINSON: There were three documents that I questioned Ms. Miller about. And I'm going to offer them as exhibits now. Exhibit 1 is the -- a five-page document entitled "Report to the Three-Member Panel," published in January 2017.

The second document is Exhibit 2. And that is the "Department of Financial Services' Analysis to Determine if a Statement of Estimated Regulatory Costs is Required." It is undated.

And the third document is an e-mail from Ms. Miller to Andrew Sabolic dated October 3rd, 2016. It's marked as Exhibit No. 3.

(Exhibits Nos. 1 through 3 marked for identification.)

MS. HINSON: Thank you.

EXAMINATION

BY MS. DAILEY:

Q Good afternoon, Ms. Miller. Thank you for your patience with all of us today.

My name is Virginia Dailey. And I'm representing Automated Healthcare Solutions, LLC. And so, I'm going to ask you questions that focus on Subparagraph 2 of the proposed rule that relates to reimbursement disputes involving compensability and medical necessity.

Are you familiar with that proposed rule provision?

A Yes.

Q Do you recall the discussion you had with both Ms. Hinson and Ms. Gallagher earlier about, if you don't understand a question, or if you have any concerns about vocabulary, that you can stop and interject at any time?

A Yes.

Q And if any of these very-quiet folks at the table speak, let's you and I both stop speaking so that the court reporter can take down everyone's comments. Is that okay?

A Yes.

Q Great. Thank you. And thank you, again, for your patience. I know this is a long day.

Ms. Hinson's and Ms. Gallagher's questions had focused on the managed-care and contractual-arrangement provisions. I want to ask you about your role in the new rule relating to compensability and medical necessity. Were you involved in the development of that proposed rule?

A Yes.

Q Can you tell me about your involvement?

A Part of my involvement regarded the edification of the 69L-31 role in sending it down to

legal for final assessment; and then discussions that was held with David Hershel, our attorney, and Mr. Sabolic, Ms. Pugh -- and I am not sure who else participated.

Q When you took over in mid-2016 of the bureau, the -- a version of the proposed rule had already been proposed -- or circulated; is that correct?

A Yes.

Q And you stated earlier that you got involved in the drafting of the rule after the second workshop --

A Yes.

Q -- is that correct?

So, what was your role specifically? When you say you were involved in the edification of the rule, what were you doing?

A Making sure that all of the new language was highlighted; that the strike-through, as it appeared in workshop and hearing, was there within the rule, itself. So, old language strike-throughs and highlights.

Q Do you recall whether there were any substantive changes in terms of the meaning or impact or effect of the language, once you became involved?

A I -- I do believe that there were some changes that occurred between the various workshops based on comments that were submitted into the Department.

Q Okay. What is your understanding of the Department's aims in -- with the new proposed rule?

A Specifically in Subsection 2 of .0- -- .016?

Q Yes.

A (Examining document.) The Department's first position based within Subsection 2 is that the determination would only address line items not related to compensability or medical necessity.

If the petitioner has submitted documentation demonstrating the carrier authorized the treatment, the Department would issue a findings of improper disallowance or adjustments.

Q And what were you reading from when you said that?

A 69L-31.016, No. 2, that was provided by Ms. Gallagher.

Q And so, I -- I appreciate you providing the text of the rule.

A Uh-huh.

Q My question is: What is the aim or the purpose of that proposed rule?

A Providing a determination would be the purpose, outlining what that determination would be based on.

Q Is it your understanding that the Department

is currently applying the proposed rule to reimbursement disputes that come before the Department now?

A It is my understanding.

Q Do you know when the Department started applying the proposed rule to current disputes?

A No.

Q Do you know if that happened before you took over in June of 2016?

A I believe.

Q What is your understanding of why the Department began applying that proposed rule regarding compensability and medical necessity?

A My understanding is that there was discussions between the Department and downtown legal and -- and whatever generated out of those discussions, the result is the amended 69L-31.

Q And do you have an understanding of what the discussions were, or the concerns, that led to it?

A I'm not.

Q Are you aware of how the medical services section addressed reimbursement disputes involving compensability or medical necessity before the proposed rule was -- began to be implemented?

A I -- no.

Q So, now, I would like to turn to the process

for claims under 69L, as they come to your Department. When a claim is made and the carrier asserts or, I should say, denies payment, disallows payment based on compensability or medical necessity, what is your description of how the Department addresses the petition for dispute -- for reimbursement-dispute determination?

A Okay. So, actually it's not a claim, but a dispute, correct?

Q Uh-huh. Yeah.

A Okay. My understanding, as of today, correct?

Q (Nodding head affirmatively.)

A Okay. My understanding that -- the medical services section, specifically the nurses, do issue a determination. And it does not specifically address compensability or medical necessity, but addresses anything that excludes any line items regarding either compensability or medical necessity.

Q So, if medical necessity or compensability are an issue in the petition for reimbursement dis- -- now, I'm going to get it confused.

A Dispute, you're right. You're right. Dispute.

Q So, if the petition involves a claim by the carrier of medical necessity or compensability, what does the Department do with that case?

A The -- well, it's kind of a twofold. If the petitioner has the supporting documentation regarding compensability, that the treatment was authorized, then the Department will issue a findings regarding improper disallowance or adjustment.

The same could be applied as medical necessity. If authorization is granted to that petitioner and they provide the documentation -- however they capture that authorization -- then the determination would have a finding for improper disallowance or adjustment.

And then, if the line item in question is regarding compensability of medical necessity, that would not be addressed within that determination; meaning, it wouldn't address compensability or medical necessity.

Q So, if medical necessity or compensability are mentioned as a basis for disallowance, then, is it your understanding the Department simply does not address those assertions? Is that what you're saying?

A The -- I guess my understanding would be is that they would fall back into providing the reimbursement based upon whatever applicable reimbursement manual, but it does state here within the rule that it's not going to address the line items

related to compensability or medical necessity.

Q It's my understanding that the Department's current practice is to issue neither an allowed nor a disallowed code, but rather a dash sign in its determinations where there is an instance of a claimed disallowance based on compensability or medical necessity. Is that your understanding?

A I don't have an awareness of that. I don't.

Q What -- what is your understanding of what the Department's -- the final determination would say in that instance, then?

A I personally have not seen a determination. The person that could address that issue would be Lynne Metz, who is the nurse that is responsible for specifically addressing reimbursement disputes.

Q Got it. Thank you.

A Uh-huh.

Q You mentioned when we were talking about these types of disputes that, if the petitioner has paperwork showing compensability or a medical necessity, that the Department would issue a determination.

What is the paperwork authorizing compensability or medical necessity that you're referencing?

A Any documentation that that particular

provider has submitted in or captured within their system.

Q So, for example, with medical necessity, if the provider provides a letter of medical necessity to support the petition, would that be a demonstration of medical necessity?

A I believe that would be along the lines of documentation from the provider -- or the documentation from the provider that they have contacted that carrier for the authorization and submitted in their treatment plan -- right? Medical necessity would be a rendering of a doctor's opinion related to a Work Comp injury.

If the carrier agreed to that treatment and determined that it was medically necessary, that documentation from the provider should somehow capture that.

Q So, you're saying the paperwork from the provider needs to include approval or agreement by the carrier in order to --

A Some way of supporting that there was a communication that existed between that healthcare provider and -- and that particular carrier.

Q So, under the current practice, if the carrier claims that the injury is not compensable and disallows payment, and the Department says in its determination,

we're not addressing this, what recourse do you understand the provider has?

MR. DOUGLAS: Form objection, simply in terms of the term "injury" versus "treatment."

MS. DAILEY: Okay. Let me --

MR. DOUGLAS: Go ahead with that.

MS. DAILEY: Yeah, I -- I think that's okay. Go ahead and -- my terms may be inartful, but do you understand what I'm asking?

MR. DOUGLAS: She can still answer it.

(Laughter.)

THE WITNESS: Because compensability -- to me, compensability can be found within 440.13(1) because it defines what compensability means. And only a carrier of the Judge of Compensation can define compensability.

So, as far as an injury, I do not -- it is my opinion that the Department does not have the statutory right to define a compensable injury. I think that's "D" maybe that -- that has that definition within the statute.

Am I right?

MR. DOUGLAS: Yes, ma'am.

THE WITNESS: The new kid gets it right.

MS. DAILEY: Excellent memory. Excellent

memory.

THE WITNESS: I did say on record that this job is educational, right? It is an educational opportunity.

(Laughter.)

BY MS. DAILEY:

Q It is. It's been a learning process.

A It has been a continual learning process.

Q So, if I can understand what you're saying, you're saying that, if a carrier asserts the issue of compensability, the provider should go to the Judge of Compensation Claims to address that issue.

A My statement in relation to your question about compensable injury is that that can only be defined by statute, by two people. The carrier and the JCC can only determine a compensable injury.

(Background noise.)

(Discussion off the record.)

BY MS. DAILEY:

Q Do you have any experience with providers bringing claims, cases, before the Office of the Judge of Compensation Claims?

A I do not.

Q So, is it your opinion that the Department does not have the statutory authority to render a

determination where the carrier asserts compensability or medical necessity as the reason for its disallowance of payment?

A It is my understanding the statute says, regarding compensability, that there are two entities that control that, the carrier and the JCC, regarding compensability.

Q Sure. So --

A However -- can I -- can I --

Q Please. Please.

A But -- but within that rule, it does say, if the petitioner submits documentation demonstrating that the carrier authorized that treatment, then the Division will issue a findings of improper disallowance or adjustment.

Q Okay. I understand what you're talking about --

A Uh-huh.

Q -- in terms of the authority and the definition of compensability. I -- I hear what you're saying.

My question is a slightly different question.

A Okay.

Q I'm asking: If there is a reimbursement dispute of a petition filed by a provider, and a carrier

asserts either compensability or medical necessity, is it your opinion that the Department doesn't have the statutory authority to make that determination to say, yes, it's medically necessary or, no, it's not?

A I really think that's a -- a legal opinion of defining that within the statute of compensability. And I -- I don't feel that I'm qualified to address that, as far as a legal opinion.

With the Division's position is, is that, if that line item is involved in a compensability or medical-necessity issue, that would not be addressed.

Q All right. Let's move into the next step of the process.

A Okay.

Q So, using the scenario we've discussed, a provider submits a petition for reimbursement dispute. The carrier disallows, based on either compensability or medical necessity. The Department issues a determination that it will not address compensability or medical necessity.

What is your understanding of what comes next for the provider or carrier?

A They have the -- the right -- I believe there is a right that they can appeal the Department's determination.

Q And what's your understanding of what the dispute would be if they appealed it? Who wins at -- at the Department level and then -- so that, when they go to appeal, who's challenging it? Do you see what I'm saying?

MR. NEMECEK: Form.

MR. DOUGLAS: Form.

A Both sides could appeal. So, I -- I don't think -- it depends on who --

Q That's a -- that's a fair point.

My -- I suppose my question is: If a provider seeks reimbursement, the carrier disallows for medical necessity or compensability, and the Department's determination is, we don't do this determination, and then, let's assume that the provider appeals it to the Division of Administrative Hearings, it seems to me the legal effect of that determination is a denial of reimbursement to the provider. Do you agree?

MR. NEMECEK: Form.

MR. DOUGLAS: Form. Predicate.

A A denial coming from the Division?

Q (Nodding head affirmatively.)

A I don't necessarily think that would be a denial.

Q What -- how do you understand the -- what do

you understand the consequence of the Department's determination to be?

A A determination -- well, if -- it depends. If the petitioner has the documentation to show that that treatment was authorized, then the Division is able to render a finding of improper or -- improper disallowance or adjustment. So, then, the finding would support that there was an improper disallowance.

If there's no documentation, then, that line item simply wouldn't -- there would -- there would be no -- there would be -- no determination would be addressed specifically for that line item.

Anything else submitted in the dispute regarding any other line item would be addressed.

Q Okay. And that -- so, that second scenario is exactly what I'm talking about where there is not a determination because there's been a disagreement between the provider and the carrier. The Department will say, we're not addressing it.

So, my question is: What's the consequence of that, not addressing it to the provider?

MR. NEMECEK: Form.

A I -- I don't know what that consequence would be.

Q Ms. Gallagher pointed you earlier this morning

to Section 440.13 of the Florida Statutes. Can you identify any provision in there or in any other Florida statutes that provides an exception to the reimbursement-dispute process for cases involving compensability and medical necessity?

MR. DOUGLAS: Could you read that back?

THE WITNESS: Yes, I don't --

(Question read back.)

MR. DOUGLAS: Form objection and --

THE COURT REPORTER: I'm sorry? Form objection --

MR. DOUGLAS: Form objection and then probably on the statutory reference as well.

You can answer.

MS. HINSON: You can answer.

THE WITNESS: And what was that, 440.13?

BY MS. DAILEY:

Q Uh-huh.

A And what specific section?

Q Uh-huh.

A All of 440.13?

Q Well, I'm asking: What is the basis for the proposed rule that creates an exception for reimbursement disputes involving compensability and medical necessity?

A Okay. One more time? Under -- under four -- Chapter 440.13 --

Q In 440.13 or any other provision, what is the authority that -- for the exception to reimbursement disputes addressing compensability and medical necessity?

A Okay. In 440.13(1), it does address the compensability as far as who can determine the compensability of the injury. The medical necessity, I -- I have no idea.

MS. GALLAGHER: Excuse me. Did you say 440.13(1)?

THE WITNESS: Yes, "D" -- it talks about compensable injury.

MS. GALLAGHER: Oh, okay. The definition.

THE WITNESS: Uh-huh.

MS. GALLAGHER: Okay. Sorry.

THE WITNESS: That's okay.

BY MS. DAILEY:

Q Can I also refer you to Section 440.13(9), that addresses expert medical advisers. Are you familiar with that provision?

A (Examining document.) This copy doesn't have it. This copy does not have --

MR. DOUGLAS: Do you want the book?

THE WITNESS: Yes, please, because this does not have the EMA.

MS. DAILEY: Thank you, Mr. Douglas.

THE WITNESS: Yes, No. 9, EMAs.

BY MS. DAILEY:

Q Are there EMAs within your bureau?

A No.

Q There are none.

A No.

Q Are -- does your bureau or any of the work under your supervision utilize the work of any of the EMAs?

A Yes.

Q And how does that happen?

A An EMA, if -- if there is a question about utilization, of a utilization review, that would require an EMA to evaluate that and make a determination.

Q Can you explain that? I'm not following you.

A An expert medical adviser is a doctor that has -- there is a tutorial that a doctor must go out and complete in order to be certified as a -- an EMA. And I believe the Judge of Compensation can also appoint an EMA.

It is a medical doctor. And the medical doctor reviews, in my -- my understanding of it is, is

that they would be required to review the medical records for that injured worker, and then, that EMA would be able to determine, because they are a medical provider, whether or not that treatment is medically necessary.

Q And in what circumstances does that happen now?

A I'm not aware that -- in the last year that I have been the bureau chief -- that we have utilized an EMA. Prior to that, I would have no knowledge. You would have to ask Ms. Macon.

Q Would an EMA be able to have the expertise to look at a petition for reimbursement dispute where the carrier asserts non-compensability, and make a determination on that?

A Again, I would think that's a legal opinion regarding the compensability because the -- the statute does define compensability as being applicable to -- based on a carrier or the JCC. So, that would be a legal opinion as to whether or not an EMA could address compensability.

Q How about -- same question regarding medical necessity.

A They probably would be able to address.

Q What would the process be for the medical

services section to have access to an EMA for reimbursement disputes?

A Well, the processes would be -- is the medical services section would actually have to go out and see if there was a specialist that was similar to the doctor that provided the care to be able to render that opinion. So, it would be peer-to-peer.

Q Who within the Department or the medical services section would decide whether a petition justified the use of an EMA?

A The nurse.

Q In the year in which you've supervised the medical services section, has a nurse ever requested the assignment of a -- an EMA from a medical-necessity reimbursement dispute?

A I am not aware.

Q Are you aware, if a nurse did make such a request, what would the process be? What happens?

A The nurse would have to go and see if there is an EMA that's available within that specialty to be able to address the -- whatever question regarding that dispute.

Q Would the nurse need approval from you or anyone else within the Department to do that?

A I don't -- I -- I don't believe so.

Q So, the nurse in the medical services section has the discretion to decide either, I have the medical experience to make an assessment myself, and they make it; or, I don't have it, and I'll go get it through an EMA; or, I don't have that experience, and the Department won't decide it?

MR. DOUGLAS: Could you repeat that, please?

(Question read back.)

MR. DOUGLAS: Form objection. Predicate.

THE WITNESS: I'm not really sure I understand the question. Is this in relation to medical necessity?

BY MS. DAILEY:

Q Yes. Sorry. I should have clarified.

A Okay. So, my -- my option is the nurse has the authority to make a determination based upon their credentials?

Q Correct.

A The answer to that would be yes.

And Part B is --

Q If the nurse does not have the medical credentials to address the substance of the issues, what are her -- his or her options?

A If the nurse felt that they did not have the appropriate credentials, that particular case would be

rolled up to the supervisor of that unit. And she and I would take that to our legal department to provide us assistance in how to appropriately address that dispute.

Q So, the nurse would not have the option to hire an EMA to issue an opinion?

MR. DOUGLAS: Form objection.

A They -- they absolutely could; however, we would want to make sure that we rendered a legal opinion to make sure that the determination was appropriate.

Q Under what circumstances would it be appropriate to hire an EMA to resolve a medical-necessity dispute?

A I can't define that.

MS. HINSON: What was the question? I'm sorry.

(Question read back.)

MS. HINSON: And her answer was?

(Answer read back.)

MS. DAILEY: Ms. Miller, I see you fanning. I know we're all warm. Do you want to take a break?

THE WITNESS: No, I'm fine.

(Discussion off the record.)

BY MS. DAILEY:

Q In your tenure as bureau chief, have you requested the hiring or budget approval for hiring EMAs

on your team?

A I have not.

Q I would like to ask you about the notice of correction from May of 2017. In your discussion earlier, I believe with Ms. Gallagher, you mentioned that the notice of correction referenced a statement of estimated regulatory costs, but that it wasn't ready at the time of notice of correction; is that correct?

A No. I believe my statement was, or should have been, that when the initial notice was placed in FAR, it indicated that the MRA and the SERCs were not completed by the Division. And that actually was incorrect. I'm not sure what timeframe they were done because Ms. Macon was the bureau chief at the time.

The notice of correction that was filed in May was to update that we -- that the Division did, in fact, complete those.

Q Just to go back to a question we talked about earlier, do you understand -- what is your understanding of what the Division is trying to accomplish with the proposed rule regarding compensability and medical-necessity reimbursement disputes?

A I -- my understanding would be -- is that the Department feels that it is trying to facilitate or provide guidance for a more-self-executing system.

Q How does the Department's refusal to address compensability and medical-necessity disputes facilitate a self-executing system?

A Well, my -- my assessment would be -- is that, again, looking at what we have done with what the Division has done with the rule is, if the documentation is provided by the petitioner, that the treatment that is in dispute was authorized, then the determination can be rendered based upon an improper adjustment.

Regarding compensability, it's not, I guess, in my opinion, the Department's refusal, but compensability of the injury seems to be a provision between the carrier and the JCC.

With medical necessity, we can provide a determination outlining the reimbursements based upon the applicable reimbursement manual of how that can look. So, again, it's providing the assessment of what could be.

Q I just want to follow up on that comment. You said you're providing an assessment to the parties of what could be?

A Based upon the reimbursement manual, the -- there are the reimbursement manuals that are applicable to both the ASC, the hospitals, and the healthcare providers. And there are MRAs. If there are not MRAs,

then it gives a breakdown of -- I think it's outpatient, 75 percent, and then outpatient surgery for -- I'm not sure -- the 60 percent.

Q Not a memory quiz. That's okay.

A 75, 60 percent.

Q Not a memory quiz.

A It should be.

(Laughter.)

Q I guess my question, though, is: If the purpose of the reimbursement-dispute process is to facilitate a resolution when the provider and the carrier can't get there on their own, how does the Department saying, we're not going to step in and resolve those medical-necessity and compensability disputes -- how does that facilitate the resolution?

A If it provides a -- if it provides a determination that is sent to both the petitioner as well as the carrier or insurance entity in question, one -- one would hope that those two parties -- because it is a small field -- that they would be able to effectively communicate and get those issues at hand.

And it also goes back to, I think, in my opinion, accountability for both that provider as well as the carrier. Whatever role each provider has in obtaining the authorization from the carrier, how be it,

whether they're instructed by attorneys or they're AP&P, there -- there is protocol within every healthcare provider of doing that. Some of -- have Work Comp coordinators or the billing department. And they send faxes or e-mails that can be responded to.

So, you know, there -- there are mechanisms that can be obtained from both sides in facilitating the execution of the system so that it is workable for both.

Q Are you aware of the numbers of petitions for reimbursement dispute involving compensability or medical necessity in 2017?

A I am not.

Q Is that information available to you or someone within your Department?

A There is a probability that it could be done.

Q Okay. Who within your Department would have access to that type of a data?

A That would be within the ARAMIS system. And the person of expertise would be LaVounia Bozman.

Q Does Ms. Bozman report to either Ms. Macon or Mr. Sabolic?

A No.

Q Any -- any of the folks who we're already talking to, for example?

A She is a direct report of Theresa Pugh.

MS. DAILEY: Okay. All right. I think that concludes my questions at this time.

Jennifer and Julie, do you all have any follow-up?

MS. HINSON: I don't.

MS. GALLAGHER: Did you have any redirect?

EXAMINATION

BY MR. DOUGLAS:

Q I had a short -- Ms. Miller, is it safe to say, in the past year in which you've held the position, you've now memorized every -- the 170-something pages of Chapter 440?

A That is correct.

Q And you were asked a lot of questions about where in the statute it might say this or that. But if I remember correctly, you didn't reference Section 440.13(3)(a), but you referenced getting authorization -- provider getting authorization from the carrier as it relates to the proposed rule.

Do you recall you testified --

A Yes.

Q -- to that effect?

And if I understand correctly what the proposed rule is meant to accomplish is, it says, we're not going to get into, for example, compensability, but

if the provider attaches documentation of authorization, then we will presumptively rule in their favor?

A That's correct.

Q Okay. Is that because 440.13(3)(a) requires the provider to have authorization in advance of treatment, except in the case of emergency care?

A Yes.

Q So, is that a threshold for payment?

A Yes.

Q And does the proposed rule basically say, if you cross that threshold, we will presumptively rule in your favor?

A Yes.

Q But if you didn't get that, we will not presumptively rule in your favor?

A Yes.

Q Does that accomplish the purpose of putting the providers on notice they have to get that pre-authorization?

MS. HINSON: Object to the form. It's leading.

Q Do you know one way or another whether that was part of what the Division was intending to put the parties on notice of?

MS. HINSON: Object to the form. There's no

predicate.

A Yes.

MR. DOUGLAS: That's all I have.

MR. NEMECEK: I don't have any questions.

THE COURT REPORTER: Anything else?

MS. GALLAGHER: I don't have anything further.

MS. HINSON: I'll just ask one more.

FURTHER EXAMINATION

BY MS. HINSON:

Q Ms. Miller, we did ask you a lot of questions about 440.13. Was there any time that you were asked about 440.13 and you did not have the opportunity to review the statute prior to answering our question?

A That would be correct.

Q Correct, you always had the opportunity?

A Yes.

MS. HINSON: Okay. That's all I have.

(Whereupon, the deposition was concluded at 2:24 p.m., and the witness did not waive reading and signing.)

CERTIFICATE OF OATH

STATE OF FLORIDA)
COUNTY OF LEON)

I, the undersigned authority, certify that the above-named witness personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 21st day of July, 2017.

ANDREA KOMARIDIS
NOTARY PUBLIC
COMMISSION #GG060963
EXPIRES FEBRUARY 09, 2021

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF LEON)

I, ANDREA KOMARIDIS, Court Reporter, certify that the foregoing proceedings were taken before me at the time and place therein designated; that my shorthand notes were thereafter translated under my supervision; and the foregoing pages, numbered 1 through 134, are a true and correct record of the aforesaid proceedings.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 21st day of July, 2017.

ANDREA KOMARIDIS
NOTARY PUBLIC
COMMISSION #GG060963
EXPIRES FEBRUARY 09, 2021

ERRATA SHEET

I have read the transcript of my deposition, Pages 1 through 134 and hereby subscribe to same, including any corrections and/or amendments listed below.

DATE: _____ _____
CHARLENE MILLER

(FL SOCIETY OF AMBULATORY SURGICAL CENTERS, INC., ET AL. V. DFS ET AL.)

PAGE/LINE	CORRECTION/AMENDMENT	REASON FOR CHANGE

DATE OF DEPOSITION: July 6, 2017

REPORTER: ANDREA KOMARIDIS