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; BUSINESSFIRST INSURANCE COMPANY; and RETAILFIRST INSURANCE COMPANY,

Intervenors.

_____/

DEPOSITION OF:	LYNNE METZ
AT THE INSTANCE OF:	Petitioners
DATE:	September 18, 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:

REPRESENTING HCA HEALTH SERVICES OF FLORIDA, INC., d/b/a OAK HILL HOSPITAL AND HSS SYSTEMS, LLC, d/b/a PARALLON BUSINESS PERFORMANCE GROUP:

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Tallahassee, FL 32302

REPRESENTING AUTOMATED HEALTHCARE SOLUTIONS:

VIRGINIA DAILEY
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Tallahasse, FL 32301

REPRESENTING THE INTERVENORS:

RALPH P. DOUGLAS, Jr.
McConnaughhay, Coonrod, Pope, Weaver & Stern, P.A.
1709 Hermitage Boulevard
Tallahassee, FL 32308

REPRESENTING THE DEPARTMENT OF FINANCIAL SERVICES:

TABITHA G. HARNAGE
CHRISTINA PUMPHREY
Department of Financial Services
200 East Gaines Street
Tallahassee, FL 32399

INDEX TO WITNESS

LYNNE METZ

INDEX TO EXHIBITS

NO.	DESCRIPTION	MARKED

*No exhibits were marked for identification

*Huh-uh is a negative response

*Uh-huh is a positive response

D E P O S I T I O N

Whereupon,

LYNNE METZ

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 Ms. Metz, my name is Jennifer Hinson, and I represent Oak Hill and Parallon Business Performance Group in this matter.

Have you had your deposition taken before?

A Yes, I have.

Q Okay. So, you know how it goes. I ask you questions and you respond. It helps the court reporter if we don't talk over each other; helps if you answer in yes and no rather than head nods.

And if you have any questions -- if you don't understand my question, please let me know. If you need to take a break, please let me know. And I guess that's about it.

Can you state your name for the record.

A Lynne, L-y-n-n-e, Metz, M-e-t-z.

Q And what is your title here at the Agency?

A I'm a registered nurse consultant in the

medical services section.

Q Okay. And what does that job position include? What are your job duties?

A Okay. I have several posi- -- jobs within my full-time position.

Q Okay.

A I do approximately a half-time position resolving reimbursement disputes between healthcare providers and insurance carriers.

In the mix of the other half-time position, I work on the promulgation of rules, writing of the re- -- three reimbursement manuals, as well as editing, making sure the case managers within the Department -- or the actual medical services section and throughout our bureau -- that is, the program administrator, the bureau chief, and up through upper management -- have an opportunity to read these, edit, et cetera.

Once that is routed through the Division, I go back to drafting again, make sure all input is put in. Once everybody is settled, the rule documents are created. A partner and I do that. We double-check. We get those together. We route them for the proper signatures, and then my partner submits those downtown at the Larson Building to go through legal.

I have -- a third part of my position is doing

utilization review, as we call it. And that would be when a carrier submits a report of healthcare-provider violation. I review the documents.

I'm the only nurse that does this, but say, for instance, overbilling, improper billing, issues related to some of the violations that are listed in the rules -- we look at these violations. The carrier must substantiate the violation with supporting documentation, taking a look at where the area is; does it require an expert medical adviser or doesn't it, based on the substantiation or the level of the allegation. We look at these.

If it requires an expert medical adviser, I make assistance suggestions as to what type of provider, what type of specialty. That is routed upward through upper management and our EMA database. Pardon me. Selections are made within that, but I do not make the final selection of the EMA.

And then, there are standard, routine forms that go out to offer those services. If someone selects those services, there is a contract made somewhere else. Then the reports -- the copying of the appropriate documents are made in my unit, and it is sent out.

Q Okay. Are you a supervisor of any kind?

A No, I'm not.

Q Okay.

A Pardon me. I have a -- (coughing). There we go.

Q No problem. And if you need to take a break, you just let me know --

A I'm good.

Q -- and we can go off the record.

My client is -- clients are primarily concerned with Rule 69L-31.016 regarding the reimbursement disputes. Are you familiar with that?

A Yes.

MS. HINSON: And our -- our specific concern involves Paragraph 1 only. And I'm going to give you a copy of that just -- of the proposed rule -- just so that you can familiarize yourself with it, in case you need to refer to it during my questions.

It's just the same one I've been using.

MR. DOUGLAS: Sounds good.

BY MS. HINSON:

Q Okay. It's this one right here, and it's Paragraph 1.

A Thank you.

Q So, when I ask you questions, unless I specify otherwise, if I refer to the -- the proposed rule, it's

that Paragraph 1 of that rule I just mentioned.

Are you involved at all in reviewing lower -- lower-cost regulatory alternatives that are submitted by interested parties with regard to specific rules?

A No, I'm not.

Q Okay. Then you're not familiar with the lower-cost regulatory alternative that my client, Parallon, submitted.

A I know one was submitted.

Q Okay.

A But I do not have any involvement with the development of what we call SERCs, estimated regulatory costs. That is delegated to, quote, my partner that is within the unit.

Q And who is that?

A His name is Mark Harrell, but he does not make any decisions, nor does he write them up as the final writer.

Q Now, it's my understanding from some other testimony of your colleagues that there was a time when the Agency did consider reimbursement-contract terms and apply those terms when they were making reimbursement-dispute determinations. Is that your understanding as well?

A Let me ask: Are you talking only about

reimbursement agreements directly from a provider to a carrier?

Q I'm just talking about reimbursement contracts, whether it's directly between a provider and a carrier or if it's one of those agreements where there's sort of a middleman, and the middleman contracts with the provider on one side and contracts with the carrier on the other. It would be either of those.

What I'm not talking about in this question is a managed-care arrangement.

A Thank you.

Q So, is it --

A At one time --

Q Oh --

A -- yes.

Q Okay. Do you know about when that was?

A I'm going to estimate that that was up until approximately 2014 -- maybe later, but 2014.

Q And do you know why the Division decided to stop considering and applying contract terms?

A I was notified by my supervisor, program administrator at that time, to stop.

Q Right. Do you know why the Agency made that decision, is my question.

A We were informed that there was no statutory

authority.

Q And during the time frame that you did apply contract terms, did you ever do one of those types of determinations?

A Yes.

Q Okay. And I'm going to ask you to explain the process that you would use here internally when you would apply those contract terms. And then my -- my follow-up question to you is going to be: Describe that process now that you don't apply those.

A Okay.

Q So, if you will, just start, what the process was when you were applying those.

A When I applied what we call a direct contract between a healthcare provider and an insurance carrier or representative of a carrier, the first thing I would look at is the healthcare provider's name listed on that contract; is the health- -- excuse me -- insurance carrier's name listed on that contract; are there signatures for both of those entities; is it dated.

And then, going up to the top of the text of that contract, we only require the, as I call it, relevant portions of a contract at that time. Well, the relevant portions needed to provide us with things such as the terms of the contract, the beginning date, the

end date, any exclusions to that contract. It needed to provide enough details so we know what's included, what's excluded, what are the actual reimbursement rates.

This is a very difficult topic because sometimes we would get an entity to an entity to a payor to a TPA to a contract. And then the que- -- or we would get multiple contracts. So, the difficultly comes down to, what do we apply.

Q Well, when you would have one of those decisions where it was difficult to determine what to apply, how would you handle it?

A I would take that to my program administrator. Very often, my understanding is, if he could not resolve that, he would take that document and go to legal.

Q Okay. And who was your program administrator?

A At that time, it was Eric Lloyd.

Q Okay. Okay. Do you know if there were other steps that were taken once it went up to your supervisor and, I guess, maybe was sort of out of your hands at that point?

A Yes, it was.

Q Okay. Do you know what -- any other steps that the Agency took after that to try to clarify the -- the issue?

A I do not know the actual steps.

Q Okay. Did it ever come back to you -- after it left your hands and went to Mr. Lloyd and up the chain, did it ever come back to you saying, oh, Lynne, here, we've figured it out; go ahead and finish your determination?

A They would come back, and sometimes they would say, this is not an -- it does not fulfill the definitions of a valid contract. Sometimes it would come back and say, here are the -- here is the contract to be applied this way.

Q Okay. If they came back and said it wasn't a valid contract as far as they could tell, then what did you do?

A I would reimburse based on the maximum fee schedules that the three-member panel authorized us to do, which would be the fee schedules.

Q Okay. And would there -- would you make a notation of some sort in your determination that you weren't able to apply the contract because it didn't seem like it was valid?

A I didn't. I would have expected that to come because I generally asked for something in writing. So, if there was something in writing, an e-mail, notes or something, I would print that, generally.

Q Okay.

A Sometimes it was purely verbal. I would move forward.

Q And during that time frame -- and I'm going to use the example that, you know, you got word from your supervisors that there wasn't a valid contract, so you completed the determination using the MRA.

When you did it that way, during that time frame, if you found that the carrier had underpaid, were they required, under that 30-day provision in the statute, then, to reimburse the healthcare provider, pursuant to the MRA?

A The determination is made that they have underpaid. How it is resolved after it leaves here, I do not know.

Q Well -- okay. That's fair.

What I -- what I do know, though, is that the determinations at that time had a provision that said to the carrier, you know, you've been -- if you've been found to und- -- to be -- to have underpaid, pursuant to Florida Statutes, you've got 30 days to pay it.

A Uh-huh.

Q You've got to send us in proof. So, that's what I'm referring to.

In those situations, when there was a

contract, but your supervisors didn't think it was valid, so you made a determination based on the MRA, was the carrier instructed to pay pursuant to those guidelines that I just stated?

A I can't answer that directly because, once it leaves my office, I do not follow the procedures beyond my office of making the determination.

Q Do you draft the document once you make the determination? Are you the one that fills out that determination document and sends it along?

A Yes.

Q Oh, okay.

A The actual determination, whether it's underpaid, paid correctly -- yes.

Q Okay.

A I fill out the determination, but then I pass it to someone who mails it out Certified to all parties. And after that, it's out of my hands.

Q Okay. During the time frame when you were applying contract terms, did you have contracts that were fairly straightforward and you didn't have any difficulty applying the terms?

A Yes, some.

Q Okay. Do you have -- are you able to estimate, maybe on a percentage basis, about how many

determinations that came across your desk during that time frame that did involve a reimbursement contract?

A I couldn't estimate.

Q Are you able to say a lot, about half, little, hardly any -- are you able to generalize that way, just to give me an idea?

A Not with the percentages that change within my half-time FTE.

Q Okay.

A My volume would go up; my volume would go down. Sometimes I would be pushed over to doing a hundred percent of other things; and then, sometimes I'm a hundred percent determinations.

There would be no way to ascertain that.

Q Okay. And is the reimbursement-dispute-determination process, at this point, now that you're not applying contract terms -- is it different? Have you noticed an appreciable difference?

MR. DOUGLAS: Form objection. Vague.

Q You can answer, Ms. Metz.

A Okay. (Indicating.)

Q Yeah, it's okay. They -- they all may be making objections. And when that happens, if you will, just stop talking, and let them make it for the record. Almost always you're going to be able to answer it once

they're done.

A Thank you.

Would you repeat that please?

MS. HINSON: Yeah.

Could you read that back, please, Andrea?

(Question read back.)

THE WITNESS: I personally have not known an appreciable difference, but that's due to the types of determinations that I do. I do what are the called the complex cases.

BY MS. HINSON:

Q And what is a complex cases?

A We call them that. It's just a term that we use upstairs in medical services. They are the non-physician-dispensed cases.

Q So, they're cases that are not --

A Okay. They're ambulatory surgical centers. They are hospital inpatient or outpatient or diagnostic lab -- anything occurring within a hospital. They may be practitioner claims, but they are practitioner claims that do not relate to physician-dispensed medications. We divided those out.

Q Have you ever done a physician-dispensed determination?

A Yes.

Q And do you agree with the characteristics of the ASCs and the hospitals being more complex?

A They are -- they do require more medical knowledge, and the claims require more multiple-line items and the reading of more medical documentation.

Q Okay. So, I understand that there were difficulties when folks would send in their contracts, and it was hard to know what terms to apply and hard to even know, it sounds like, if you had all the terms that you were supposed to apply.

Did the Agency ever attempt to streamline that to make it easier on the Agency to apply those terms? And I guess -- let me put it to you this way because it doesn't seem like you understand. It might not have been very coherent, actually.

It seems to me that if you had a petition form, for instance, and you made the provider and the carrier actually go through and say, for this line item on the dispute, this is the term -- you know, the reimbursement term from the contract, and you know -- it seems like you -- the Agency could have potentially done something like that.

So, that's the type of activity I'm referring to when I ask, did the Agency take any action to sort of help make it a little more streamlined and clear for the

dispute-determination process.

A The Agency is not taking any action because a contract is a private agreement between those two parties. My understanding -- at least my view -- is that would get into contract law and those two attorneys, or something thereabout, developing their own contract. We have no control over what is put into two contracts that are outside of this Division.

Q Well, that's -- I understand that. But wouldn't you agree that the Agency has exclusive jurisdiction to decide reimbursement disputes?

MR. DOUGLAS: Form objection.

A The three-member panel, which is selected by the Governor, is the entity that determines the maximum reimbursement disputes for all the schedules. And it does not state anywhere that I can find that there is an action taken or a reimbursement amount or action that is taken regarding contracts.

Q Well, that's sort of funny you say that because all of the reimbursement manuals that you work on are full of references to reimbursement being either at the MRA or -- and I'm quoting the manuals now -- the agreed-upon contract price.

So, your own reimbursement manuals reference the fact that it's permissible and that reimbursement

shall be the MRA or the agreed-upon contract price.

MR. DOUGLAS: Form objection. Argumentative.

MS. HARNAGE: Well, there -- I don't know if there's a question. I'm sorry.

MS. HINSON: Yeah, I mean, I haven't finished the question, yet, but you can go ahead.

MR. DOUGLAS: Okay. Well, go ahead and finish the question, then.

MS. HINSON: Okay.

BY MS. HINSON:

Q So, I'm -- I'm not clear as to why you just stated there wasn't any sort of basis to apply contract terms.

MR. DOUGLAS: And --

A The three-member panel --

MS. HINSON: Oh, hang on one second, Ms. Metz.

MR. DOUGLAS: Same objection. Also, you referenced the manuals that say agreed-upon contract price, and there's a lack of predicate because the contracts don't typically reference any price.

MS. HINSON: Okay.

MS. HARNAGE: We'll join that.

BY MS. HINSON:

Q Right. So, you know, maybe the manual doesn't

say price. When I say "price," it could be mean rate. Let me see what this says. The manual, I think, incorrectly says "price" because Mr. Douglas is correct; it's not a contract price; it's a reimbursement amount. That's what the manual should say, but it doesn't.

But my question still stands: Based on this language in the manual, I'm confused as to why you would say that there isn't anything that gives a basis for the Agency to determine a dispute based on a contract price.

MR. DOUGLAS: Same objection.

If you can answer, go ahead.

A That -- the three manuals are rules, Florida Administrative Code rules. The three-member panel is established under Florida Statute. And Florida Statute has more -- pardon me -- delegation over rule. And the three-member panel is our authority and only our authority to give us permission to determine reimbursement allowances.

It does not state in the maximum reimbursement allowances an action that we should take regarding a contractual price. Do we accept? Do we deny? Do we send to an outside entity?

Q But nobody is asking you whether you accept the contract price or charges. That's not -- that's not what the providers are coming to you for. The providers

are saying they should have rep- -- they should have reimbursed me X, Y, and Z.

Let's just, for instance -- let's say the contract says 60 percent of the MRA -- right? The carrier should have reimbursed me 60 percent of the MRA. We need you to make the determination as to whether or not you think they did that.

MR. DOUGLAS: Form objection.

A I'll state it again that the three-member panel did not provide the Division with an authority to price contracts as far as we take an action to price them.

Q Well, but the Florida -- the statutes do. Florida Statutes do. I mean, reimbursement dispute under Florida Statute is defined as any disagreement between a healthcare provider or a healthcare facility and a carrier concerning payment for medical treatment. Any --

A Uh-huh.

Q -- disagreement. So, is that not authority?

A A petition --

MR. DOUGLAS: Form objection.

A -- for resolution of reimbursement dispute would not filed if there isn't a dispute. So, a dispute says nothing about a contract.

Q Well, a dispute most certainly can. I mean, the dispute --

A No, it says nothing.

Q I'm not following you. You're going to have to explain that one because I'm lost.

A If there is a dispute over a fee-schedule amount, it is still a dispute.

Q Correct. And if there is a dispute over a contract reimbursement amount, it's still a dispute, correct?

A It's a dispute, in their minds. They have to substantiate that dispute.

Q Okay. And so, if they send you in a dispute and say, they should have paid it 60 percent of the MRA pursuant to our contract, does that not substantiate the dispute that you're supposed to make the determination on?

A Not when we do not have the authority from the three-member panel to act on a contract.

Q Well, you know, the -- the three-member-panel section of the statute, which is Section -- just for reference, for the record, it's 440.13, Paragraph 12. It's entitled, "Creation of three-member panel guides of maximum reimbursement allowances."

And right there, in that section, it says: An

individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

A Uh-huh.

Q So, you've got acknowledgment -- in fact, a command, that it shall be reimbursed at one of those two things right there in the three-member-panel section. So, again, I'm confused as to -- to your testimony, as to why you keep saying that there's no authority.

MR. DOUGLAS: Form objection.

MS. HARNAGE: Hold on.

Is there a question?

MS. HINSON: Well, I just said: So, I'm confused as to why you're stating that there is no authority. Can you please explain?

MR. DOUGLAS: Incomplete.

MS. HINSON: I'll -- I'm going to give -- do you mind if I give her the statute so she can take a look at it?

MS. HARNAGE: Uh-huh.

MS. HINSON: I'll direct you to (12), since that's what we're talking about right now.

MS. HARNAGE: 440.13(12)?

MS. HINSON: Yeah.

THE WITNESS: Uh-huh.

MS. DAILEY: Tabitha, I have an extra copy, if you need it.

MS. HARNAGE: No, I'll just look it up. Thank you.

THE WITNESS: (Examining document.) I'm going to skip into a few sentences and start reading some of this.

MS. HINSON: Okay.

THE WITNESS: -- starting with the word "the panel" --

MS. HINSON: Okay.

THE WITNESS: -- everybody.

MS. HARNAGE: Yes.

THE WITNESS: "The panel shall determine statewide schedules of maximum reimbursement allowances for medically-necessary treatment, care and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment.

"The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per-diem rates to be approved by the

three-member panel no later than March 1st, 1994, to be used in conjunction with the precertification manual, as determined by the Department, including maximum hours in which an outpatient may remain in observation status, which shall not exceed 23 hours.

"All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges, except as otherwise provided by this subsection.

"Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, schedules of maximum reimbursement allowances for phys-" -- excuse me -- "for physicians, hospital inpatient care, outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs.

"An individual physician, hospital, ambulatory surgical center, pain program or work-hardening program" -- I agree -- "shall be reimbursed either the agreed-upon contract price or the maximum reimbursed allowance in the appropriate schedule."

But the Division does find a determination for the maximum reimbursement allowance. Since we are

not a party at all to that contract, we provide a decision or a determination on the maximum reimbursement allowances, which is all that the three-member panel has given us, an action and a dollar amount in which to do our function.

Q Okay. We can agree to disagree on that. I think that's a legal conclusion. I think it's incorrect, but we can agree to disagree. And I will tell you that this Section 12 is not being implemented by the proposed rule. So, what this section says is almost irrelevant as it relates to Paragraph 1 of that rule because this isn't what it's implementing. Okay.

You've got a statute here that says that the DWC -- well, I guess it's really the Department -- has exclusive jurisdiction to decide reimbursement issues, and then you've got a definition of a reimbursement issue that says, it's any disagreement between a healthcare provider and a healthcare car- -- or excuse me -- a Workers' Comp carrier concerning payment for medical treatment.

So, I don't understand where there is a distinction or some sort of permission, for lack of a better word, that allows the Agency to exclude agreed-upon contract prices in their determinations. Am I missing something? Are you aware of anything else in

the statute that -- that gives you some sort of authority to do that?

MS. PUMPHREY: Asked and answered.

Q I need you to answer out loud.

A Not at the moment.

Q Okay. Have you heard anybody within the Agency, either here at the Division or anywhere in the Department of Financial Services, express any sort of concern about the legality of this rule?

A No.

Q Let's switch gears and talk about reimbursement disputes that include managed-care arrangements. So, all of my answers [sic] up until now have been about reimbursement contracts. And let's switch gears.

Have you -- has the Agency ever made determinations based on the terms of a managed-care arrangement when one was alleged?

A Since I have been employed with DWC -- sorry -- the Division, no.

Q And I'm sorry. When did you say you --

A Pardon me.

Q Oh.

A Yeah. Okay. I'm going to say no.

Q Okay.

A For -- for me.

Q For you.

A Uh-huh.

Q So, no, not during the time that you've worked here or you just --

A No.

Q -- specifically, you personally haven't worked on one?

A No, not for the time period I have been here.

Q Okay. And I'm sorry that I don't remember this, but when did you start working here?

A December of 2007. Yeah, I have to back up a little.

Q Okay. So, December of 2007 to present with no interruptions?

A I'm sorry?

Q You've worked here from December of 2007 to present with no interruptions?

A That is correct.

Q And during that time frame, you're saying that, to your knowledge, the Agency hasn't done any determinations that included -- excuse me -- that involved a managed-care arrangement.

A I personally have not done any.

Q Do you know if the Agency just sort of

generally has done those, even if you personally haven't handled one of those?

A I know that the rule was repealed. I cannot tell you about other people's determinations.

Q You're talking about the rule that said you have to --

A I'm sorry. Not the rule; the statute.

Q Oh, okay.

A Uh-huh.

Q What statute are you referring --

A I'm sorry.

Q -- to? Let me help refresh your memory, and tell me if this is correct. People before you have referred to a rule that required basically an automatic dismissal of a petition --

A Uh-huh.

Q -- if -- if it alleged a managed-care arrangement. Is that what you're talking about?

A Uh-huh. Uh-huh. Yes, on its just up-front face value.

Q Yes, ma'am.

A Thank you. A petition on its up-front face value, it's substantiated.

Q Okay. And I do know that the Agency repealed that.

A Yes.

Q And so, if you've already answered this, I apologize, but after the repeal of that, to your knowledge, did the Agency -- even if you didn't do it personally, did the Agency make determinations when a managed-care arrangement was involved for a period of time following the repeal?

A Possibly. There was a time period when I was not doing determinations.

Q Okay. Thank you.

In your opinion, does the proposed rule -- and again, it's Paragraph 1 of the rule before you --

A Uh-huh.

Q Does the proposed rule have an impact on hospitals?

A No.

Q And tell me why that's your opinion.

A This proposed rule has no impact here. This is not a rule that should be determined here.

Q I'm sorry --

A Under DWC, DFS.

Q Can you --

A You're requesting about managed care.

Q Okay. Let me broaden my -- my question, then: Without regard to managed care or a contract,

reimbursement contracts, does the application of this rule affect or impact hospitals?

A They are given the maximum reimbursement allowance. Their contract is between the healthcare provider and the insurer. They can determine the correct amount based on what the Division determines is the absolute maximum they may receive.

Q How can they do that?

A How can they do that?

Q Yeah.

A We have a fee schedule. We have a fee schedule, which was authorized by the three-member panel, which tells us particularly for per-diem rates, then, again, for the outpatient line-item codes, which are based on actual charges from hospital line-item data reported to the Division, which actually is the median average data for each CPT code that is determined with a threshold of actually 50 bills or more to produce a fee schedule so that, when that procedure code is billed for an outpatient service, there is a maximum reimbursement allowance.

If it's not on the list of what we call an MRA, it would receive either 60 percent of billed charges pursuant to the statute or 75 percent of billed charges pursuant to the statute.

Q Well, I still don't understand how telling two parties who have a dispute, whether it's a reimbursement contract that's involved or a managed-care arrangement that's involved -- if they have a dispute and they can't figure out how it should be reimbursed under either of those arrangements, how is telling them what the MRA is supposed to help them resolve their dispute?

MS. PUMPHREY: Asked and answered.

A The dispute that the Division may resolve is if the applicable maximum reimbursement is correct.

Q How --

A If they state the contract is not correct, that is contract issues --

Q Nobody asserts --

A -- which has no rel- --

Q -- the contract isn't correct.

A Have no relation to the Division.

Q Well, that's not what the statute says, actually. I know that's your opinion because you keep saying it, but that's not what the statute says.

MR. DOUGLAS: Form objection.

Q And people aren't asking you to determine whether a contract is correct. What they're asking you to do is they're asking you to say, the contract says this should have been reimbursed at 60 percent of the

MRA. Apply the contract and tell me if it's correct, the same way that you would apply the MRA.

MR. DOUGLAS: Form.

MS. PUMPHREY: Form.

MS. HARNAGE: I don't think there's a question.

MS. PUMPHREY: -- question.

BY MS. HINSON:

Q So, isn't that true?

A They are not asking us in these disputes to completely ask us to apply just contract.

Q Oh, they're not?

A They're asking us to make sure that all of the components of this contract are in there. The question on the petition form is to provide the relevant portions. Relevant is, in my opinion, vague.

Q Fake?

A Yes.

Q What did you say?

A Vague.

Q Oh, vague. Yeah, it is sort of vague. So, why didn't the Agency ever define "relevant"?

A Why didn't the provider give us those portions they feel is relative to reimbursing a dispute over the contract?

Q Perhaps the healthcare provider and the carrier both submitted what they thought was relevant, but you just said the term was vague. So, my question to you is: If it's so vague, do you know why the Agency didn't clarify "relevant" to help with this problem?

A Very often, the healthcare provider submits one contract; the carrier submits a different contract.

Q Is there a reason you're not answering my question?

A No.

MR. DOUGLAS: Form objection.

MS. HINSON: Okay.

MR. DOUGLAS: (Inaudible.)

THE COURT REPORTER: I'm sorry? What was that?

MR. DOUGLAS: Form objection to the line of questions. Asked and answered. And it's argumentative. --

BY MS. HINSON:

Q Do you know --

MR. DOUGLAS: -- as opposed to substantive.

Q -- why the Agency didn't better-define "relevant" since it's vague, according to your testimony. I'm ask- -- that's my question to you: Do you know why?

A This is a contract issue.

Q You are not answering my question.

A That's all I have to answer.

Q No. Do you know why the Agency didn't define what is considered to be a relevant portion of the contract?

A We do not define portions -- we don't define what one party, in their legal terms, would define as relevant to them, and another party as to what is relevant to them.

If we stated, you had to have A, B, C, X, W, and Z, and this party, the same document -- there would, then, be a discrepancy between the two because you still come down to the problems of petitioner puts in a different contract than carrier.

Q Well, isn't the issue not what's relevant to them; it's what's relevant to the Agency making the determination?

A That's not all.

Q That's not all?

A No. The carrier-contract and the petitioner-contract issue is far-more confusing than that.

Q I think we all agree it's confusing. And I think you've already testified that what is relevant to your determination is vague.

You still haven't answered my question: Do you know why the Agency did not define what is a relevant document that needed to be submitted so you could -- so the Agency could make a determination?

MS. PUMPHREY: Asked and answered.

MS. HINSON: She hasn't answered is the problem.

MS. PUMPHREY: I understanding that you're not liking the answer you're getting.

MS. HINSON: I'm not getting an answer.

BY MS. HINSON:

Q Do you know why? The answer is yes or no. I haven't gotten that answer.

A Not needed.

Q It wasn't needed to define what a relevant portion of the contract is?

A It is not needed to tell a carrier, if they feel they need to enter a contract, what is their business need to write a contract in such a way that it spells out the required components of a contract to a healthcare provider.

Then those documents become the relevant portions that they need to submit for a dispute.

Q Thank you for answering my question.

When the Agency did make determinations, when

a -- in this case, I'm going to use reimbursement contract -- was involved -- when the Agency did make a determination, and the determination said, under the terms of the contract, Carrier, you owe X, Y, and Z, did that have an impact or affect a carrier or a hospital?

A An effect on what?

Q Did it impact them? Did it affect them in any way? When you made such a determination, would that determination have any sort of effect or impact on a carrier, in your opinion?

A Not necessarily.

Q So, a determination that said, Carrier, you're required to pay within 30 days because you underpaid -- that didn't affect the carrier, in your opinion?

A Not necessarily.

Q How so?

A The carrier can substantiate that they have made proof of payment according to the terms of this contract. And therefore, the payment is in full.

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

Ms. Metz, look, I know you keep sighing and rolling your eyes. And I'm sorry.

A I'm not rolling my eyes, Ms. Hinson.

Q This is boring for all of us, I know, but I'm

just asking you to explain that answer because I don't understand it.

A I'll give you a scenario.

Q Okay. That's just fine.

A If you owe someone a hundred dollars, and they give you a discount of 10 percent -- so, you pay them 90; it's balance due of 10. That's it. There's a balance due.

Their cash register says it was technically underpaid, but verbally, in that store, that man or whatever -- I say retailer -- had already discounted that item. Balance due on the books is $10.

Now, come at the end, somebody has to pay that $10 to make the books even. There was a contract between that mass purchaser and that store. They have to even and balance those books, and it wouldn't be the single customer that came in and bought that dress.

MS. PUMPHREY: Can we take a ten-minute break?

MS. HINSON: Yeah.

(Brief recess.)

BY MS. HINSON:

Q I'm going to wrap this up. Ms. Metz, you are listed, I believe, by the Agency as one of their witnesses that they're going to present at trial. Are you aware of that?

A Yes.

Q Okay. And do you know what subject matter you're going to be testifying about?

A Not really.

Q Okay. Well, I mean, I think we can assume it may involve reimbursement disputes. Is there anything out of the reimbursement-dispute area that you know of that you would be testifying about?

A No.

Q Okay. And are you going to be relying on any documents during your testimony at the hearing?

A No.

MS. HINSON: That's all I have.

EXAMINATION

BY MS. DAILEY:

Q Okay. So, now it is my turn. Good morning, Ms. Metz. I'm --

A Good morning.

Q -- Ginny Dailey. I am one of the attorneys representing Automated Healthcare Solutions in this proceeding. We are focusing on the provision of the proposed rule relating to disputes where the carrier asserts disallowance based on compensability or medical necessity.

Are you familiar with that provision of the

rule?

A Yes.

Q So, all my questions will relate to that provision of the proposed rule as opposed to Subparagraph 1 that deals with contracts and managed-care arrangements. Is that clear?

A That's clear.

MS. DAILEY: So, my first question is -- and I'll refer you to Chapter 69L-31. This is a provision of the rules.

And Counsel, this is just a copy of the rules.

MR. DOUGLAS: Thank you.

THE WITNESS: Thank you.

BY MS. DAILEY:

Q So, if you can, please describe the process internally for a reimbursement dispute when the carrier fails to submit a response.

MS. PUMPHREY: And I'm sorry. Is this the current rules or the proposed rules?

MS. DAILEY: Either. That's a good --

MS. PUMPHREY: I just meant, which one did you give her? The current rules or --

MS. DAILEY: Oh, no, these are the currently- --

MS. PUMPHREY: Okay.

MS. DAILEY: -- in-place rules. Sorry.

THE WITNESS: Just a moment (examining document). Okay.

BY MS. DAILEY:

Q So, what happens when the carrier fails to respond to the petition?

A I would like to back up just a moment.

Q Okay.

A When a -- a dispute -- petition for dispute arrives, it is date-stamped into our unit. The chart, as we like to call it, is put together in sort of an organized manner. It receives a case number, which is an automated number; has to do with year, month, day, et cetera. It is also -- and Division tracking number. That number is not as important.

And then there's a rotational way that these are dispersed to the nurses; five, five -- I think right now, I'm two. I never know what I am. And then, we screen them to make sure that the initial intake folks have entered the right information into our computer system.

Then, as I screen -- obviously the information is looked at -- that I physically look at the dispute form. I check for all the information on there. I check to see that the date that the petitioner received

the EOBR from the carrier matches with the timeliness rule.

If it does not, that constitutes an automatic dismissal. Whether the carrier responds or not makes no difference. So, that goes in a different stack. It's just -- as we say, it's out of here. So, there are certain cases that do not matter. That's the type of case that is out.

Another type of case that we would not make any form of determination on is out-of-state cases. We do not make determinations on out-of-state cases, cases that involve federal workers, longshoremen, these types of cases.

So, that's how we -- almost all of us -- I can't think of anybody that wouldn't. We sort of sift through those cases and pull them out, make sure all of our screenings are done on the valid cases, and then we take -- first in, first out. That's the order. You work oldest to newest.

So, you obviously make sure everything has been received within the time of 45 days from the date of receipt of the EOBR, the verifiable login, and the other one, I -- yeah -- the issue date plus five days and the calendar days. You have those different ones.

Obviously, you have to wait 30 days from the

date that the carrier received the dispute with all of its supporting documentation. And we add five days to that for mailing. We give them the full five days. If there's a holiday day in there, we add one -- if it's during the week, we add one more day to that.

If a carrier does not respond, the carrier has waived their rights, meaning they've -- they've waived rights to the dispute in the petition, and the petition is determined based on all the documentation that is in evidence. If a carrier does file a dispute, and it is untimely, we don't consider it. And a determination is made in favor of the petitioner.

Q Now, I would like to refer you to the proposed rule. I think you may have it in the document Ms. Hinson gave you. Paragraph 2 says that, "The healthcare provider must demonstrate authorization for treatment from the carrier."

MS. HINSON: Excuse me. That --

MS. PUMPHREY: -- is the old one.

MS. HINSON: -- is an old version of your rule.

MS. DAILEY: Ah. Okay.

THE WITNESS: Yes.

MS. DAILEY: If we can stop for a moment, then.

(Discussion off the record.)

BY MS. DAILEY:

Q So, are you familiar with that language?

A Paragraph 2?

Q Yes.

A Subparagraph 2, in parentheses. Thank you.

Q Okay.

A When the carr- -- this is under reimbursement disputes involving a contract; is that correct?

Q No, ma'am. I'm --

A .016?

Q .016 Subparagraph 2, yes. And I'm looking for Paragraph 2, right.

A Yeah.

Q Okay.

A I was going to read it.

Q Oh, I see, you were reading the rule title.

A I was reading the title first.

Q Uh-huh.

A And then I'm going to read two.

Q So, you don't need to read the rule, but my question was: Are you familiar with this paragraph of the proposed rule --

A Yes.

Q -- including the final sentence that talks

about demonstration of authorization?

A I'm familiar, but for the record, she doesn't necessarily know what I'm familiar with.

Q Okay. Tell us what you're familiar with.

A Rule 69L-31.016(2) says: When the carrier asserts the treatment is non- -- not compensable or medically necessary and, as a result, does not reimburse, the determination will only address line items not related -- doo, doo, doo, doo -- (examining document) -- this is all stricken -- to compensability or medical necessity.

If the petitioner has submitted documentation demonstrating the carrier authorized the treatment, the Department will issue a finding of improper disallowance or adjustment.

MS. DAILEY: Okay. Thank you.

Can I now also refer you to Rule Chapter 69L-7 --

THE WITNESS: Yes.

MS. DAILEY: -- that lists the EOBR codes.

And Counsel, I have an extra copy if y'all --

MS. PUMPHREY: I have that.

BY MS. DAILEY:

Q Are you familiar with the EOBR codes?

A Yes.

Q Is there an EOBR code for authorization or lack of authorization?

A Yes.

Q What code is that?

A Got to find it (examining document).

Q Is it Code 30?

A Probably.

Okay. EOBR -- and that's capitalized -- 30, payment disallowed, lack of authorization, no authorization given for service rendered or notice provided for emergency treatment, pursuant to Subsection 440.13(3), F.S.

Q So, if a carrier disputes that authorization was provided, there is an EOBR code on which to make that disallowance or dispute; is that right?

A Makes that allegation, yes.

Q So, can we assume, then, that in cases where there is not an EOBR Code 30, the carrier is not disputing authorization?

A Let's break that out, please. One question.

Q Where you have a reimbursement dispute and the carrier does not assert Code 30 in the EOBR, can we assume the carrier is not disputing authorization?

A Only if there's no other substantiating document within the carrier response.

Q Can you explain what you mean?

A There are different EOBR codes. There are what we call Division-approved EOBR codes, and there's something that we call workers -- excuse me -- carrier-unique EOBR codes. A compliant EOBR code is using the Division's EOBR codes.

There's other situations where the carriers choose to use their own. They are supposed to use the Division's EOBR code in the first position. We allow up to three.

As long as they have a Division EOBR code in there, you know, either in position two, position three, we accept it. We also will accept it if they use a carrier EOBR code, but it absolutely has to state no authorization given.

Q So, if you have a reimbursement dispute and the carrier EOBR does not state a lack of authorization, whether that's using the Division's code, Code 30, or a carrier-unique code -- if you have no statement from the carrier asserting lack of authorization, does the Division assume that there is authorization?

A If the carrier responds to the reimbursement dispute in a timely manner and provides no objections to authorization, then the Division moves forward as long as the carrier provides no dispute.

Q Okay.

A I'm sorry, or the carrier has reimbursed for it.

Q Well, certainly the provider would not object to that.

Okay. So, then going back to the proposed rule language, in the last sentence of Subparagraph 2, it says that the Division will make a finding if there is a demonstration of authorization for treatment. Are you with me?

A I'm with you.

Q What is a demonstration of authorization for treatment?

A A document- -- documentation could be a fax from the petitioner, the name of the pers- -- a fax containing the name of the adjuster, an e-mail. It could be a letter. It could be a specific authorization code, but it cannot be the claim number.

I'm trying to think of any other possibilities. It can be an authorization that comes through for specific services only, Service A, B, but not C and D. And it's signed by an adjuster for the particular either designee for the carrier or the actual carrier, and it is dated.

Q So, there must be some written documentation

of this authorization; is that a fair understanding?

A It may be verbal.

Q But if there is a verbal authorization, you're saying that there must be something signed by the carrier or the carrier's designee?

A It may be verbal, whereupon you get the name, the title, and their title as far as their relationship to the carrier, and the date of the authorization.

Q So, it does -- it is not required to be signed by the carrier or the carrier's designee?

A Not in certain conditions.

Q And what would those conditions be?

A The ambulatory surgical centers, I know, do this; emergency services that are authorized after the fact that can do that.

Q What about a physician that is dispensing medication from his or her office?

A I'm sorry? My hearing aids. Go ahead, repeat.

Q What about a physician that is dispensing medication from his or her office? Is there a requirement for such authorization to be in writing?

A It may be. That is depending between individual carriers, their preference. And it depends also on the service that the healthcare provider is

requesting authorization for.

Q Can you describe a service that would require a written authorization as opposed to one that would not?

A A physician wants to do a little bit more of an advanced office-level visit, but he also wants to withdraw fluid from a joint. So, it's what is considered a bit of an invasive procedure. So, an authorization comes in for both procedures, not just authorize and treat.

Q So, in that instance, where a physician wants to do an office-level visit and withdraw fluid from the joint, the Division would require written authorization for the invasive procedure? Is that what you're saying?

A I didn't say the Division. I said, it's up to each carrier about what they require.

Q So --

A I've also seen authorization regarding IV infusions given in certain types of offices, for dehydration, situations like that, a special drug. I have seen, absolutely, physician-dispensed medications.

Q Sorry. When you say, I have seen, absolutely, physician-dispensed medications, what do you mean? Do you mean that those --

A You may visit, but you may not dispense; you

may do a visit and you may dispense. It goes both ways.

Q You have seen carrier authorizations that state either you may -- the physician may dispense the medication or the physician may not dispense medication; is that --

A Correct.

Q Okay. And in the absence of a specific statement in writing, in the paperwork, what does the Division assume is the scope of the authorization?

A If the carrier is reimbursed, the carrier has given -- generally, if they have paid -- paid properly -- then you would take that at face value only if the carrier did not respond; that the response has to be the correct response within the correct time frame for that correct service.

Q So, if the carrier pays that line item for the physician-dispensed medications, the Division assumes that the authorization included that medicine; is that right?

A We would request that authorization from the petitioner to see if the petitioner received that authorization because the actual verbiage says they must receive the authorization in order to be eligible for reimbursement.

Q And when you refer to the actual verbiage, are

you referring to Section 440.13(3) that deals with authorization in the Florida Statutes? I can give that to you.

MS. DAILEY: Counsel, I'm giving her Section 440.13 of the statutes, if anybody needs a copy. I think we all have many.

BY MS. DAILEY:

Q So, if you will, go to Paragraph 3, Ms. Metz.

A 1-3 -- is that what you --

Q Sorry. Subparagraph 3 titled "Provider eligibility; authorization."

A 440.13(3)(a), "As a condition to eligibility for payment under this chapter, a healthcare provider who renders services must receive authorization from the carrier before providing treatment." This paragraph does not apply to emergency care.

Q Okay. Thank you.

If you could, now, turn to Subparagraph D in that provision.

A Uh-huh.

Q Does that provision allow for verbal authorizations not signed by the carrier or documented by the carrier?

A By telephone -- a carrier must respond by telephone or in writing from an authorized healthcare

provider. A carrier who fails to respond to a written request for a referral for medical treatment by the close of the third business day -- and I want to reiterate, this is for authorization for a referral -- notice to the carrier does not include notice to the employer.

Q Okay. My question was: Does that provision of the statute allow non-written authorization or verbal authorization?

A By telephone, yes.

Q Does it allow verbal authorization that's not signed by the carrier or documented by the carrier?

A Must be documented in certain cases. It says in writing. I can't tell you when.

Q Sure, but does it allow authorizations that are not in writing that do not have any writing from the carrier?

A That is correct, but "A" states they must receive authorization.

Q Okay. Thank you.

A And "D" is not just for authorization of any service. "D" is for specific referrals.

Q Okay. So, tell me what -- how is that different, authorization for referral -- how is that different from authorization for treatment?

A Authorization for treatment is for what we call the primary care provider. "D" is when the primary care provider then requests a referral to what we consider a specialist or another provider.

Q Okay. Going back to Rule 69L-7, specifically Rule 7.740, which is the list of EOBR codes -- are you familiar with that rule?

A Yes.

Q And does that rule include all of the Division-approved codes a carrier can use responding to a claim for reimbursement?

A I would have to compare it to the current rule, but I believe it does.

Q Can you explain Code 10, please.

A Code 10 is payment denied, total denial. That's when a carrier denies the entire claim -- medical bill -- I'm sorry. I call them claims. They deny everything.

Q And what is the basis for denial in a case where the carrier uses Code 10?

A The best scenario that I can come up with is that claim for injury for that employee has been closed. That date of service for that specific work-related injury has been closed.

Another one could very well be the condition

for which they were injured was an ankle injury. Now, they come back in with a different injury, not work-related. They show up to the emergency room for a sprained wrist which they got while bowling.

The sprained wrist is absolutely not related to the employment injury. So, the medical bill for sprained wrist would be denied using Code 10. It's a total denial for that emergency room visit.

Q And Code 10 is different from Code 30, which addresses authorization, right?

A Yes, it is, slightly, very slightly.

Q Using your sprained-wrist example, can you explain how they would be --

A They both went to the emergency room. The wrist went to the emergency room. There is no author- require -- authorization required for emergency services.

Q If you remove the emergency component of the -- of the case -- let's say the patient goes to the doctor with a sprained wrist, and the doctor provides treatment -- I'm -- I'm trying to use the example that you gave me. So, let me go back and look at it.

In that instance, the example you gave, the patient had a sprained ankle -- or an injured ankle that was a work-related injury and now goes to the provider

with a sprained wrist. In that instance, what code typically would you anticipate the carrier to use to deny payment or disallow payment?

A I would like to clarify this. The ankle injury was compensable?

Q Yes.

A They later, of course, had the wrist, non-compensable. You said they went later back to the provider. Who was that provider?

Q Let's say it's the same provider.

A Location?

Q In the same location.

A That would be the emergency room.

Q Oh, I'm -- I'm sorry. I'm asking you to assume that neither of these was at the emergency room, the --

A Okay. But the first -- the second one was. That's --

Q Okay.

A -- why I'm asking.

Q Okay. Let's assume neither of these injuries was treated in the emergency room, but treated, rather, in a doctor's office.

A So, let's rephrase this, please.

Q So, if the patient first visited a doctor's

office with an ankle injury that was work-related and compensable, and then visited a second time and presented a wrist injury, and the carrier denied treatment, would the appropriate code for denial be Code 10 or Code 30?

MR. DOUGLAS: Form objection.

A Ten, but they could have also appended a 30 if no authorization was provided and the practitioner did not feel it was an emergency.

Q Now, before the proposed rule that we're talking about was put in place, in that scenario, how would the Department have decided a dispute, a reimbursement dispute between the provider and the carrier, regarding that sprained-wrist visit?

A I would have to see the EOBR from the carrier to make a full answer since this is office-based.

Q And would the -- in general, would the Department have issued a determination in that instance?

A We always issue a determination.

Q And is it your testimony that now, under the proposed rule and the policy that's now in place, that the Department would issue a determination in that dispute?

A Yes.

Q In that determination, it's my client's belief

that the determination says in these disputes involving compensability or medical necessity, the Department will not address them. Are you familiar with that language?

A Yes.

Q My client believes that that is not a determination of the dispute. It is a statement that you will not determine the dispute. Do you agree with that position?

A I can't say I agree or disagree. It's a decision.

Q Do you believe that the decision or determination from the Department in that instance resolves the dispute between the provider and the carrier?

A I'm sorry. Was what?

Q In that instance --

A Uh-huh.

Q Let's -- we're using, still, the same example where you have a sprained wrist that's unrelated to the original work-related injury, and the carrier gives you a Code 10 and says it's not compensable. In the new policy or the proposed rule, the Department will issue a determination that says, we will not address that line item.

Do you believe that resolves the dispute for

that line item between the provider and the carrier?

A Yes.

Q And what is the basis for believing that?

A By not taking any action on certain things, you are still making a decision. This occurred a few times before this proposed rule where we could not make, on a single line item, decisions on that single item. And we would also state that.

Q And so, essentially, you are saying, in your determinations, under the proposed rule, we can't make a decision on this line item and we're not doing that.

A That's correct, and specifically compensability.

Q Before that new policy -- so, before this new rule or the -- let me back up. It's my understanding that the proposed rule that was issued in May of 2017, with an earlier draft issued in December of 2016, was -- came after a policy change in the Department sometime in 2015.

Do you know when that policy change was made with respect to reimbursement disputes where the carrier asserts compensability or medical necessity?

MR. DOUGLAS: Form objection. Overbroad as to policy change.

A Instead of taking the time line backwards --

Q Sure.

A -- I would like for you to take the time line forward, please.

Q Certainly. Was there a time when, in contrast to the process that you would take now with a dispute where the carrier asserts Code 10, compensability, was there a time when the Division would address that line item in a reimbursement-dispute determination?

A No. That is not our decision to make.

Q Okay. Is there documentation that a carrier could show to the Department to show that a claim was non-compensable or to support its assertion of non-compensability?

A Yes.

Q Okay. Can you give me examples of that?

A A DWC-12 form -- it is issued to the provider, which may be more than one provider in the case of a practitioner and a hospital. A copy is also mailed to the injured employee state- -- based -- I'm going to, in summary, state what -- they're not responsible for further costs of this claim.

Q Sorry. You said that "they" are not responsible --

A The carrier.

Q Got it. Thank you.

What about a -- an order from the Office of the Judges of Compensation Claims? Would that demonstrate non-compensability from the carrier?

A Yes. A carrier and the Office of the Judges of Compensation Claims are the only two parties that may decide compensability. The Division cannot.

Q And when there is documentation of non-compensability, such as the letter to the employee, the form, or the OJCC order, would the Department rule that the disallowance was appropriate because the claim was non-compensable?

A Yes.

Q Now, without that documentation, would the Department make the same ruling or finding?

A If the carrier notifies the partition -- the petitioner with the EOBR Code 10 on the EOBR, that is their notice to the petitioner that they declare non-compensability. That is accepted. They're not required to submit all of those documents.

Q When you think about the timing of a patient's treatment and how that works through this system, when the patient goes to the doctor -- and everything I'm asking about is not a hospital and not emergency treatment.

So, assume the patient goes to see a doctor

for an ankle injury, and the provider receives, let's say, verbal authorization from a carrier to provide treatment, and the provider, then, provides treatment, diagnoses an injury, prescribes medication and dispenses the medication.

In that circumstance, when the patient has already received care, what is the basis for denying compensability of the claim when there was no denial up front from the carrier to the provider?

A I can't answer that. I don't know what the carrier is thinking.

Q Would you agree the provider is in the same boat that you are; also don't know what the authorization is -- sorry -- what the carrier is thinking?

MR. DOUGLAS: Form objection. Incomplete hypothetical.

Q You can answer.

A I don't know what the carrier is thinking and I don't know that they're thinking like me or me like them.

Q Is it your belief that if a carrier believed a claim was non-compensable, would the carrier authorize a doctor to treat a patient?

A They shouldn't, but it may slip past an

adjuster if the information has not reached that adjuster in time.

Q Can you give an example where that might occur?

A No. I don't know all of the processes within a carrier.

Q So, now, I would like to turn to Code 11.

A Uh-huh.

Q Can you -- are you familiar with that code?

A Yes.

Q Does Code -- does the use of Code 11 actually acknowledge that there is a compensable injury suffered by the worker?

A What this means -- and I was involved in the wording and some of the issues around this EOBR code. What this code was developed for was, instead of controverting the entire claim because they had no option -- you know, okay, that's not compensable, (indicating), okay, and just taking whole claim out, they could look at different line items. Unfortunately, it's developed a problem there that we're now working on.

But carriers used to look at all the care, and if there was one piece of care line item that they felt was probably not compensable, they would just use

EOBR 10 for the entire medical claim. EOBR Code 11 forces the carrier to look at it at line by line by line and have to relate it to the compensable injury.

What it does is make them look at the body as a whole -- they insure the body as a whole, so they have to look at that; allows a partial denial, not the whole claim. And there are times when you have a patient that has a chronic condition that has to be treated in order to stabilize them, in order to treat the compensable injury.

I think of cardiac conditions. They may be very, very mild, but if you do not maintain them on their blood pressure medication, you have a worse patient and, yet, their problem is their knee injury.

I think of other things, you know, hips, shoulders -- you know, people come to you with other stuff in their body. And you must maintain that other stuff or you're creating a complication.

We have some things that are partial denials, but it's not used very often. We find with the existence of this code, it is not used very often.

Q Do you know if the use of that code has changed since the Department began including the language in the determination that it will not address disputes where the carrier asserts non-compensability?

A I've never looked at that.

Q So, with respect to a line item where the carrier is -- the carrier uses Code 11, the carrier is not asking the Division to make a decision about compensability, are they; the carrier is merely asking to define the scope of that injury?

A Code 11 is also related to the compensable injury, but they are detailing it down to either the procedure, possibly the diagnosis and that actual condition. But they are not taking away all the ancillary services, chronic medications that the patient entered the hospital, doctor's office, ambulatory surgery with.

Q Okay. So, in cases where the carrier uses Code 11, the Department is making decisions on line items where they are not -- where the carrier is not disputing compensability; is that right?

A You said the carrier is not -- that is correct. They are only citing certain line items on the EOBR using Code 11. The Division will not address Code 11.

Q Would you agree that authorization is distinct from compensability?

A They work twofold, but they are separate functions, but they go together.

At the time of authorization, a carrier should know and is expected to know that the specific service requested for authorization is either compensable or non-compensable.

Now, no one is perfect in an imperfect world. If it goes through and the petitioner obtains the proper authorization, adjudicated, the petitioner disputes that bill, it comes through. If the petition- -- EOBR comes out non-compensable, the carrier -- or the petitioner has the authorization, then we've already detailed in this rule what will happen. The carrier didn't respond. We have detailed the outcome of that.

Q And what would the outcome be? I'm -- I'm not following your example. Where the carrier does not respond --

A Correct.

Q -- to the request for authorization --

A Correct.

Q So, what -- what is the -- what would the determination be from the Department?

A The carrier has not only waived, the petitioner has provided the authorization for the services -- and I want to get right to that part. Let me find it (examining document). Sorry. That's the wrong document (examining document). That's the wrong

rule. Starts in the front.

MS. PUMPHREY: If you don't mind --

THE WITNESS: It's in --

MS. PUMPHREY: That one --

THE WITNESS: It's in this one. I knew it was somewhere.

(Examining document.) If there's documented authorization, the authorizing -- say, for instance, the petitioner has proof of authorization, the determination would be made in favor of the petitioner. Service was authorized. He did all -- he or she did all the steps required.

BY MS. DAILEY:

Q So, it seems like proof of authorization is being conflated with compensability here. Do you see how that is?

A It is not necessarily.

Q Okay. Can you -- can you explain that?

A It is expected for reimbursement -- as a matter of fact, it's a requirement that you must receive authorization from the carrier, multi for care. You must advise them of the service. You must advise them of where that service will be provided.

The carrier controls -- not control, but guides where the care will be. The carrier is the

ultimate party reimbursing these services, and the carrier knows all the history on this injured employee.

If the carrier has issued a DWC-12, it may be to the hospital. It may be to the primary care doctor, but it may not be to the orthopedic surgeon. So, they have information that the orthopedic surgeon does not have. And so, they need to advise that orthopedic surgeon's office to make them aware.

So, compensability and authorization are not necessarily linked, but they are vital.

Q Under the proposed rule the Department will address compensability if the provider demonstrates authorization, but it will not address compensability if the provider does not document authorization; is that a fair statement?

A First question -- repeat it, please.

Q Under the proposed rule, if the provider demonstrates or documents authorization, then the Department will address the assertion of non-compensability; whereas, if the provider does not document authorization, they won't.

A All right. Let's stop again at the first question.

Q Okay.

A The first question was: If the provider

substantiates authorization, the Division will make a determination -- did I understand -- towards the petitioner?

Q (Nodding head affirmatively.)

A That is not necessarily true.

Q Okay.

A Because if a carrier response comes in where the carrier can substantiate they received a ques- -- a request for authorization and their response to that request for authorization included a document that says rejected on the basis of a DWC-12, and the date of that DWC-12 was prior to the service -- or other reasons, but that's the best reason.

Q Yes, I -- I agree. I understand that's what you're saying. And I -- I think the confusion is -- again, my client believes that, under the proposed rule where the Department includes that asterisk language that says the Department will not address line items where the carrier asserts non-compensability --

A Uh-huh.

Q My client views that as not making a determination, so --

A Okay.

Q So, that's what -- when I say not making a determination, that's what I'm talking about.

A Okay.

Q When -- so, what I'm asking is: If the provider substantiates authorization --

A Uh-huh.

Q -- then the Department will make a determination. Whether it's in favor of the provider or the carrier, if there's documentation of authorization, the Department will proceed on the merits of the case; is that right?

MR. DOUGLAS: Form objection.

Q You can answer.

A I think the case would have to wave on what the merits of that case are, but it would have to be substantially weighed depending on -- excuse me -- the evidence of the petitioner's side, the evidence of the carrier's side, and what it states.

But if it is substantiated -- excuse me -- proven that the petitioner received authorization, what does the EOBR say? It's not just the authorization, if the EOBR issued to that petitioner that says non-compensable -- okay?

Q Uh-huh.

A The dispute comes in. We do not have jurisdiction to resolve that dispute. The Agency for Healthcare Administration is the only body that can deal

with managed care. And compensability is out of our jurisdiction. It is within a carrier's decision or a Judges of Compensation Claims.

Q Okay. So, if a petitioner cannot substantiate authorization, then the Department, under the proposed rule, will not address that line item; is that right?

A Yes.

Q And if a petitioner can substantiate authorization, the Department may or may not address the compensability.

A That's correct. We have to go through the whole internal process, give the carrier time to respond; however, the outcome would not -- we have to turn that over to the carrier and the Judges of Compensation Claims. We have no authority on compensability.

Q Okay. All right. Do you know when the language the -- what I'm calling the asterisk language -- that the Department will not address line items where the carrier asserts non-compensability and non-medical necessity -- do you know when that asterisk -- asterisk language was added to the determinations?

A I don't know that date. Let's see. That was -- let me just think a minute. I'm thinking

sometime early summer of 2014, but I don't know the exact date. It may be later. I'm basing that on the repeal language of the managed care, et cetera. So, I may be off.

Q Okay. In your ten years with the Division, have you ever addressed any reimbursement disputes where the carrier denied payment based on compensability?

A Yes.

Q And have you -- and what has been the finding of the Department in such reimbursement disputes?

A They were -- compensability was generally the entire claim. Prior to this proposed rule, we started seeing the line-item-type disallowances. Most claims were controverted. Then we saw a few lines. As a result, EOBR Code 11 was created. They didn't have an EOBR code to use.

Q And I'm referring to the Proposed Rule 31.016 Subparagraph 2 that relates to reimbursement disputes where the carrier denies payment for compensability or medical necessity.

A Yes.

Q Prior to that proposed rule being developed, how did you handle reimbursement disputes where the carrier used Code 10?

A Code 10 line items, et cetera, were forwarded

over to the Offices of the Judges of Compensation Claims for authority.

Q Can you give me an example of a case where that took place?

A I don't have a specific case.

Q Okay.

A I can tell you how we process them --

Q Okay.

A -- upstairs.

Q Please.

A I just answered that question.

Q Okay.

A We processed them with the referral to the Office of the Judges of Compensation Claims.

Q And was that the last step at which your office had involvement in that reimbursement dispute?

A For me, yes. I do not know if the others had any other involvement -- other case managers.

Q Okay. So, now, under the proposed rule, where the healthcare provider receives authorization and the doctor sees the patient, diagnoses the condition, and prescribes and dispenses medication, then the carrier EOBR -- uses EOBR Code 10, and the provider submits a reimbursement dispute, what do you understand will be the result or the Department's determination in that

case?

A Did they use EOBR Code 10 on every line item?

Q I am referring to an instance where they use Code 10 for specific medication, but not necessarily all of the medications or line items in the claim.

A Those line items where EOBR 10 was not used in this case -- we would calculate the correct MRA pursuant to the fee schedule, the EOBR Code 10 line item would not be addressed, according to this proposed rule, and a correct total reimbursement would be calculated.

Q So, for that line item with EOBR Code 10, would the correct reimbursement amount on the determination be listed as zero or a dash?

A A dash.

Q So, in that instance, do you believe that that dash resolves the dispute about the line -- that line item between the provider and the carrier?

A Did the carrier respond to that petition?

Q Let's assume that they did.

A I need the documentation for what the carrier submitted in their carrier response to the petition.

Q But under the proposed rule, it says you wouldn't address it. So, it doesn't matter what the carrier's response says, does it?

A All documents are addressed if they meet the

timeliness.

Q Would you say, in the scenario we were talking about -- so, the healthcare provider obtains authorization, provides the treatment, dispenses the medication, and then the carrier uses EOBR 10, and then the provider submits to you a -- a petition for reimbursement, would the dispute that has the dash -- would you agree that's essentially a decision in favor of the carrier?

A No.

Q Why not?

A We look at all lines on the claim.

Q Okay. You're right.

A And the correct --

Q You're right. I should be more specific. Go ahead.

A The line that is not designated as non-compensable has been paid according to the maximum reimbursement allowance as authorized by the three-member panel.

Q Right. You are right. And I -- I'm sorry I was not precise in my question. The dash in that determination from the Department -- is the dash a finding in favor of the carrier for that line item?

A It is not in favor of either party.

Q Does the dash for that line item mean that the carrier is required to provide payment to the provider for that line item or that no payment is required?

MR. DOUGLAS: Form objection.

A It is calculated in to the correct total reimbursement. It does not add in or subtract from the correct total reimbursement.

Q So, in that addition or subtraction calculation, it's essentially a zero; would you agree?

A It's a dash. It's a non-number.

Q When the carrier uses Code 10, under what circumstances could the healthcare provider achieve reimbursement -- a finding from Department requiring reimbursement?

A The first process that we would hope that they do is contact the carrier after that obviously comes here. Contact the carrier and work through the carrier-provider communication. If they had not received a DWC-12, request one. Verify, if they get one, that the DWC-12 is applicable to that date of service, et cetera.

Q So, the circumstance you're outlining is to work it out with the carrier.

A The first step.

Q Okay. What other steps are available to a provider to receive reimbursement if the carrier uses

Code 10?

A They could -- I don't know. Those would be guesses, at least, between the carrier and the provider. I don't know that step.

Q Are there any circumstances in which the provider would get a determination by the Department that the carrier is required to make payment on a line item where the carrier says Code 10?

A If the carrier erred in either documentation or the date that the DWC-12 was issued, then the carrier would be expected to file a correction, notify the petitioner, obviously. And then an amended determination could be made.

Q Okay. Do you know what the reasons for the adding of that asterisk language to the Department's determinations were? Do you know what the reasons for that were?

A To notify entities or parties to the dispute, as to the reason there are dashes.

Q In determinations before that asterisk language was added, did the Department typically use a dash in line items where a carrier used Code 10?

A No.

Q What would the determination have said in that line item, prior to the proposed rule?

A The dollar figure would have been zero and we would have -- the grid -- do you know what I'm talking about, the financial grid?

Q I do, yes, ma'am.

A It would have had in the description non-compensable -- non-compensable, not addressed, or something to that effect, but it would not have the asterisk language.

Q Okay. Thanks.

Do you know, what was the need to clarify this issue for parties? Do you know what drove that? Was there confusion or were there concerns raised by parties?

A It wasn't parties. We felt it was a need just to clarify, based on this rule and based on a few calls, but we felt it was best to let all of our carriers, all of our stakeholders, all of our petitioners, everybody, know what a dash meant, rather than get all the calls after the fact.

And there was legal research done. I was not part of that.

Q Okay. Do you know if involving an expert medical adviser in a dispute where the carrier uses Code 10 -- would that give the Department the ability to substantively address the assertion of compensability?

A Since I have been here, in approximately 10 years, I do not know of an expert medical adviser being used for that purpose.

Q Okay. All right. So, the questions I've asked thus far have been focused on compensability, and now I'm going to ask questions about medical necessity, but we have been going for some time.

A I would like to take a break.

Q Would you like to take a break?

A Uh-huh.

(Discussion off the record.)

(Brief recess.)

BY MS. DAILEY:

Q All right. Ms. Metz, now we're going to turn to medical necessity. If you could, refer to EOBR Codes 21, 22, 23, 24, and 25.

A Okay.

Q Are you familiar with these codes?

A Yes.

Q Okay. With respect to Codes 21 and 22, these codes indicate that there was no physician's order or physician's prescription for the service rendered or the medication provided; is that correct?

A Yes.

Q These codes are not being used because the

carrier is claiming that the patient did not medically need the service or medication provided; is that right?

MR. DOUGLAS: Form objection.

A The document was not located in the medical record. It does not say that the patient needed it. That may be the wording, but it states that the document in the medical record could not be located.

Sometimes when we get a medical, what's called, audit from the carrier, they've used this EOBR code. We find it.

Q So, the use of Codes 21 or 22 does not indicate that the service or medication was not necessary; it indicates that the documentation was not in the record; is that what you're saying?

A Not always, but yes.

Q And is it within the Department's capacity to review the record to determine whether a physician's order or prescription is included?

A Yes.

Q If a healthcare provider submitted proof of a prescription showing certain medications were prescribed, is the Department able to make a determination of a medical necessity for that medication?

A Not always.

Q Why not?

A Our reviewers are registered nurses. A physician is obviously a licensed physician. We are not their peers. We cannot supersede a physician's decision-making.

Q Can you refer to Code 23?

A Yes.

Q That indicates that the physician's diagnosis did not support the service rendered; is that correct?

A It says "diagnosis." It does not say "physician."

Q Okay. So, Code 23 indicates that the diagnosis in the medical record did not support the service rendered; is that correct?

A That's correct.

Q Is this the kind of determination you believe needs to be made by a physician?

A Yes, practitioners are included there, mid-level practitioners.

Q Would the use or could the use of an expert medical adviser by the medical services section in reimbursement disputes help the Department make a determination where the carrier uses Code 23?

A That is an action that the carriers use in their EOBRs. And carriers are required to have their

own medical staff. If that is a line item in dispute, the Division medical services section for this would look at the billed procedure code. It says, supports the level of service. So, we would look first at the level of service, not the diagnosis.

Then we would look obviously, okay, EOBR Code 23 is there; what else is there. We generally find carrier-unique EOBR codes, and it tells them on what basis.

Q So, if you have a reimbursement dispute where the carrier uses Code 23 and there is not a carrier-unique code or other documentation that -- that provides additional information -- would the involvement of a physician, such as an expert medical adviser -- would that assist the Department in making a determination on that dispute?

A I can only answer that it has not been done since I've been here.

Q Do you know if it's ever been requested?

A I do not know.

Q So, I'm not asking about an -- a case where it has happened, but I'm saying, in the future, if a case were to come in that is a reimbursement dispute from a healthcare provider, and the carrier has asserted Code 23 --

A Uh-huh.

Q If you were -- as the person who typically does identify the appropriate EMA, if you were tasked with doing that, could you find an EMA that could provide peer review of the EOBR and documentation from the petitioner?

A That would be upper management's decision. I would apply the definition of medical necessity that is in the statute -- or the rule. I can't remember which one it's in. It defines medical necessity.

Q And the question of whether you could involve an EMA would be up to upper-level management.

A It would begin with my supervisor, program administrator; would, then, go to the bureau chief. From the bureau chief, it would go to the assistant deputy director. He may or may not have the authority to involve the director in order to make the decision.

Q Okay. Going to Code 24 EOBO -- EOBR Code 24 --

A Uh-huh.

Q That -- are you familiar with that code?

A Yes.

Q And it provides that a service rendered was not therapeutically appropriate; is that correct?

A Correct.

Q Is that the kind of determination you believe needs to be made by a physician or mid-level practitioner?

A Uh-huh. If you say physician, I will include those. Okay?

Q Okay. Good.

A Yes.

Q Could the use of an EMA in a reimbursement dispute where the carrier uses Code 24 -- would that assist the Department in making a determination?

A Again, this depends on which line item they've applied it to, the types of service, the site of service, and all sorts of factors, but at least it would be reviewed against the EOBR definition.

Q Okay. I'm not sure I understood what you were saying. I think what you're saying is that there are certain circumstances where the -- the nurse -- and others in your role, are perfectly capable of reviewing the carrier's use of Code 24, and that you have the expertise to address it, like the -- evaluating the line item, the site of service, et cetera, but that there would be other circumstances where, in order to achieve peer-to-peer review, it would be of use to involve an EMA.

A Yes, on a case-by-case basis.

Q And what are the cases in which an expert medical adviser would be useful? Can you give me an example?

A As I said, I have not used an expert medical adviser for a dispute. And since my employment here, I do not know of anyone that has used an expert medical adviser specifically for a reimbursement dispute.

Q Sure. I was just asking: Can you think of an example where the use of one would be helpful to achieve a peer-to-peer --

A For a dispute.

Q -- review?

A No.

Q All right. Then, Code 25 --

A Uh-huh.

Q That code -- are you familiar with that code?

A Yes.

Q And it provides that it would involve a carrier disallowance or denial of payment because the service was experimental, investigative, or research in nature; is that right?

A Yes.

Q Is that the kind of determination you believe needs to be made by a physician?

A It may, but not by DWC. Experimental,

investigative, or research in neighbor -- in nature is determined by the medical directors for the carriers. We do not make this determination. Medical directors on the carrier's side are expected to have a medical director or someone they can take these close-call cases to them.

AHCA used to -- when the DWC was under their umbrella -- settle all of these types of disputes. Since we came over here, the EOBR code was maintained because of the medical director located under the carriers.

So, we do not stay as the authoritative figure for those decisions. It's the carrier's decision. And you need to note the parentheses.

Q I'm sorry --

A "(The insurer shall provide supporting documentation)."

Q Ah, right. You're referring to the parenthetical information in EOBR Code 25 --

A Yes.

Q -- which is found in Rule 69L-7.740?

A Uh-huh.

Q Under the proposed rule, are there any circumstances in which a healthcare provider -- sorry -- in which the Division will make a finding that

additional payment is required when a carrier uses EOBO -- EOBR Code 25?

A I have not -- pardon me -- no, I have not. The only way I have ever -- and it was a small other line item -- if an other line item is on the claim -- other portions were reimbursed pursuant to the MRAs, which caused an overpayment or underpayment, it was calculated based on the MRAs.

Q Okay. I got it. Okay. Do you believe that authorization is distinct from medical necessity?

A Yes.

Q Okay. Can you explain that?

A The authorization process is may they have -- or are they eligible; is it a compensable injury; is the provider requesting, based on the injury, treatment for that injury. The carrier may guide that provider to the appropriate setting and they establish it and set a date and make sure that the claim comes in for that date, but they are not medical people; adjusters, claims coordinators -- they are not medical people. It's generally on a retrospective review that this would be reviewed.

Q If a carrier gives a provider authorization to treat a patient and that authorization does not specify limitations or a scope of that authorization, does that

limit the carrier from denying payment based on medical necessity?

MR. DOUGLAS: Incomplete hypothetical.

A No.

Q Can you give an example of that or explain that?

A It's easier to use a hospital claim for something like this. Patient comes in to the hospital, is admitted, and has usually an unscheduled or scheduled inpatient admission. The patient is in the hospital for five, maybe six days. They treat them with a lot of blood transfusions, but in the meantime, they're getting what we call type and cross match -- you know, type it, cross it, type it, cross it -- for each single unit. Well, that's blood-bank criteria.

Very often, certain people -- carriers -- will say, that's not necessary because we just did it this morning. They won't pay for the one that night because they just had one 12 hours earlier. They'll pay one the next morning, but they won't pay one that night. They call it not medically necessary.

They put a parameter down of once every 24 hours. So, that second one within the 24 hours is not medically necessary, even though the blood bank, which sits three floors down from the ICU, as an example --

the hospital is discounted or not reimbursed for the protocol within the hospital, which says twice a day, and the carrier determines that it's not medically necessary.

Q Okay. What about a physician-dispensed medication? If a carrier gives a healthcare provider authorization to treat a patient and does not limit the scope of that authorization, can a carrier deny payment for a physician-dispensed medication based on medical necessity?

A Prior to?

Q It would be after.

A Okay. After. It would depend on that medication. It would also depend on the patient's history and the patient's injury.

Q Okay. The proposed rule states that if the provider submits documentation demonstrating authorization, the Department will issue a finding of improper disallowance.

In the context of medical necessity, what does that mean?

A Did the provider get specific authorization for the dispensed medication?

Q Let's say they got authorization to treat that isn't -- that does not include any exclusions.

A But did it include dispensing medications?

Q It did not include a specific sentence including -- specifically identifying physician-dispensed medication.

A Then it's a decision upon the carrier.

Q So, if the authorization does not specifically identify physician-dispensed medications --

A Uh-huh.

Q -- then the Department will not address a disallowance by the carrier.

A If it didn't address a specific authorization -- that is correct. All services must be authorized.

Q So, where you have a reimbursement dispute and the carrier has denied payment for Code 21 or Code 22 --

A I see 21 and 22. What's your question, please?

Q If a provider shows proof of authorization, documentation of authorization, how does the authorization resolve the dispute regarding the physician's order or prescription that relates to Codes 21 and 22?

A Authorization in this case says, yes, you may do this. That does not eliminate a healthcare provider's scope of practice under the Department of

Health to provide acumen- -- accurate documentation in the medical record or a physician's order for a service or treatment provided.

In the hospital, a physician's order is required for everything. To refer them to somewhere for DME, lab work, anything -- these all require physician or practitioner's orders.

Q Okay. So, then, going to Codes 23, 24, and 25, that relate to medical necessity, does a general authorization to treat a patient constitute documentation that the services are medically necessary?

A (Examining document.) 23, not necessary for that service.

24 is more of a therapeutic. So, it sort of narrows its scope. We generally see those in the therapies and most of those.

25 is definitely medical necessity. And that one is exactly the wording out of the rule or statute because it was either experimental, investigative, or researched. An insurer has to provide that supporting documentation.

Q Okay. Before the new policy or proposed rule were adopted -- were developed, how did the Division address reimbursement disputes where the carrier used Codes 21, 22, 23, 24, or 25?

A 22, we would look for the physician's prescription. We would first identify, what service are they talking about or they reference it. Then we would look back at the petitioner's side of the evidence. We would look for it. So, you go page by page through all evidence.

23 is due to very significant clinical coding and you take a look in the CPT, which is the current procedural terminology manual and you look at what is considered the procedure code that they billed. There is a chart in there that actually tells you what did that medical provider have access to to make that procedure, visit -- office visit, hospital visit -- determination based on.

And it will tell you which office visit or whatever is determined out of the amount of information, data, X-rays, et cetera. So, if that is the question, you can look that up.

So, if the diagnosis is a code -- is a cold, and they bill the absolute most-complex office procedure, it's pretty obvious -- and that is discussed in full in the incorporated reference materials that we have as well as, for me, over 20 years of clinical coding experience.

Q So, in the event that a carrier used Code 23

and denied the medical necessity of a treatment, you believe that you did have the medical experience and training to make a decision either agreeing or disagreeing with the carrier's --

A On certain case-by-case situations.

Q And were there cases where you did not have the necessary medical expertise?

A Questionable ones.

Q And how did you handle those questionable cases?

A I made a copy of the medical bill. If it was surgery, the operative report, if it was hospital, I made a copy of the history and physical, and some very -- pretty standard things; passed them out to all of the other case managers; gave a copy to my program administrator.

About two days later, we would all meet in a group table with the program administrator and the bureau chief, and we would have a roundtable discussion. All of us are generally from different specialties. We give each other input. We would try to come up with -- okay, the approach is this; no, the approach is -- we would just brainstorm. Almost every time we would come up with the same answer.

If it was questionable again, we would go up

to upper management to see a recommendation.

Q So, in general, you had the -- you were -- the Department was able to make substantive determinations in cases where the carrier used Code 23 to deny payment?

A As I said, not always. It's case by case.

Q But it -- in general, with the exception of these questionable cases, you were able to make determinations?

MR. DOUGLAS: Asked and answered.

A I can't answer that a full yes.

Q Okay. What's the hesitation?

A I have to see the documents.

Q Do you know what the reasons for the new policy about medical-necessity cases were?

A Medical necessity was a policy and still is a policy that is the determination for the carriers to make by their medical directors. It was this way and it still is. It's really a carryover from when we were under the Agency for Healthcare Administration. We were under the Healthcare Administration when I was first hired here. And then, through reorganization or whatever, we moved over -- med services did -- to DFS.

However, there were certain powers -- whatever -- authorities that brought us over here, but didn't bring over any medical councils, any grievance

panels, any of that. And this one -- you know, is this 25 here, Ms. Dailey?

Q Are you talking about Code 25, EOBR Code 25?

A 25, this is defined, okay, as experimental, investigative, or research in nature. That is the definition of medical necessity, and we do not make those determinations because of these. We do not determine what's experimental, investigation -- investigative, or research.

Q Okay. And so, it is your view that it's the carrier's --

A Medical director's.

Q Medical director's job to make that determination.

A Absolutely.

Q Is it your understanding that the carrier's medical director ever sees the patient in-person?

A Do not know that. These are services.

Q Sure. Well, I want to just go back to the question I asked earlier: Do you know what the Department's reasons were for adding that asterisk language to the determinations that the Department will not address disputes where the carrier uses medical necessity to disallow payment?

A I just answered that to say that medical

necessity is investigative, experimental, and research in nature. That remained at AHCA when we moved over here to the Department of Financial Services. That function was left over there.

AHCA made the decision that it remained in the managed-care area. And it was decided here long before I came to work that it was based on the carrier's decision, their medical director.

Q Are you the person who, within the medical services section, hires expert medical advisers for cases other than reimbursement disputes?

A I don't hire them.

Q Are you the person who selects them or identifies people with appropriate medical expertise?

A I recommend. I do not hire them.

Q Is there anyone else within the Department who is tasked with recommending expert medical advisers?

A We don't do any -- oh, excuse me. Since I've been here, my knowledge is we haven't used any for disputes. We do use them for another process, which I'm involved with. I do not select them, but I give guidelines: this type of doctor; this type of specialty; don't use this area of the state.

And an additional staff member, then, queries our data bank of EMAs; gives us all the information.

Myself, the program administrator, and the bureau chief will sit down and go over all of those. They generally select three. They take that up to the assistant Division director and have a discussion. I am not involved in that.

After that, I'm not sure of the process. And the contracting part -- it comes back to me with, here it is.

Q It comes back to you with a contract?

A I do not even write the contract. I come back with, here is your name, and then I write the EMA questions that we would like to have answered.

Q Can I refer you again to the statute, which is Section 440.13. Do you have that in front of you still?

A Huh-uh -- do I?

MS. HARNAGE: (Handing to witness.)

THE WITNESS: Thank you.

BY MS. DAILEY:

Q Okay. If you look at Section 9 --

A I'm there.

Q Okay. Section 9 includes language in Paragraphs A and B that says the Department shall certify expert medical advisers and the Department shall contract with expert medical advisers in certain circumstances. Do you see that?

A The first one -- (examining document). Yes.

Q And in Paragraph B, it says that the role of the expert medical advisers includes providing peer review or expert medical consultation, opinions, and testimony, to the Department or to a Judge of Compensation Claims in connection with resolving disputes relating to reimbursement, differing opinions of healthcare providers and healthcare and physician services rendered under the chapter, including utilization issues.

Do you see where I'm reading?

A Yep. Yes.

Q Does the Department have expert medical advisers available to it with the requisite expertise to help with -- to help when dealing with differing opinions of healthcare providers or dealing with utilization issues in a reimbursement dispute?

MR. DOUGLAS: Form objection.

A The first -- all right. Repeat the first portion of the question.

Q Does -- let me just ask it more-simply.

A It would be easier. Break those into two.

Q Yeah. Does the Department have available to it expert medical advisers that could be used in reimbursement disputes?

A If the case was a really complicated case and truly warranted an expert medical adviser, the Department may do that. Since I have been here, in ten years, I have never seen a case that complex.

Second portion of the case -- or the question.

Q Okay. Earlier, when we talked about some of the medical-necessity codes, you -- we were talking about a peer-to-peer review. So, I'm going to give you an example to talk -- to talk through.

A Okay. May I stop you?

Q Please.

A There was a second portion of that question that you didn't repeat for me.

Q Okay. I've already forgotten it.

A It had something to do --

Q But go ahead -- yeah.

A It had something to do with utilization.

Q Right.

A Not disputes.

Q Right. I meant, in general, though, the category of reimbursement disputes. I wasn't focusing on the utilization review.

A Okay.

Q I think you testified about that earlier --

A Yes.

Q -- with Ms. Hinson.

A Because in utilization, we do use expert medical advisers, and we use them regularly. As the need arises, we do. And they do involve utilization.

Q So, it's -- this is just a layperson asking a question here, but -- so, where you have a carrier saying that a provider is overutilizing the Workers' Comp system, the -- the Department hires an expert to review the medical records, to check -- to check the assertion, but in the -- on the flip side, where a provider is saying, hey, the carrier didn't pay us, the Department doesn't hire an expert medical adviser to check that.

A That is not true.

Q Okay.

A On the first portion of the question, the Department has a mechanism wherein carriers may file what's called a carrier's report of healthcare provider violation. There are different violations; one of which can be standards of care, which includes overutilization and some other criteria.

Now, they must substantiate their allegation in order for DWC to move forward with that investigation. And we have had some that -- I think two or three that went all the way to litigation. It was

founded, et cetera. And utilization review with an EMA was used. And it was selected, different EMAs with specialties in different areas of the state.

And the reports were returned in time. And then what we do is we do a word called "staffing." We get certain key figures, everybody that is involved in -- all the way from me up through normal -- up to upper management, sit and discuss the entire case, including the expert medical advisers' opinion. And then an action plan is decided. And that action plan is implemented. Now, that is the healthcare-provider violation.

On the carrier's side, we collect information on patterns and practices of carrier misbehavior. I'm not in that section, but I do have way to collect -- you know, yes or no. Yes or no, when I do a dispute.

And that information is sent to the second floor, which is monitoring and auditing of carrier behaviors. And they collect a lot of data. They monitor as well as they go out into the field to carriers to make sure that they are following the rules.

They actually monitor EOBRs, timeliness of payment, different things like that, and penalties may be assessed. Other things can happen. And since I don't work there, I don't know all that can happen.

Q Who's the head of that program?

A Yeah, that would be Charlene Miller. She is also my bureau chief as well as the bureau chief down there.

Q And what's the name of that bureau, Monitoring and Auditing?

A Yes, we are part of that bureau. We're third floor. M-and-A, as we call them, is second floor.

So, it's a semi-provider-carrier in our unit, and it's carriers only on the second floor.

Q Got it.

A So, it is both sides.

Q Do you know what the statutory basis is for the proposed rule that the Division will not address disallowances on the basis of medical necessity or compensability?

A Compensability -- I can look. I just need a book.

Q You should have it --

A Got it. Sorry.

Q Yep.

A Sorry. Found it.

440.13 -- it's in the definition first -- (1)(k), and that's the definition. It means: Any medical service or medical supply -- I'm going to

shorten this -- used to identify or treat an illness or injury appropriate to the patient's diagnosis or status of recovery, is consistent with the location of service, level of care provided, and applicable practice parameters.

The service should be widely accepted among practicing healthcare providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of experimental, investigative, or research in nature.

Q And so, that --

A I have compensable.

Q Okay. And you don't need to read that definition. We have -- we have that in the record.

A Okay.

Q But I recognize you're referring to the definition of compensable in Section --

A In (d), but it means a determination by a carrier or Judge of Compensation Claims.

Q And that language, "Determination by a carrier or Judge of Compensation Claims" -- "Compensation Claims" -- is that language in the statute with respect to medical necessity? Is there any language that says the determination of medical necessity is only by the carrier or the OJCC?

A No, but the carriers are required to do utilization reviews on their claims after they adj- -- either before, during, or after they adjudicate and pay claims, they are required to do utilization review.

Q Can you point to any language in the statute that explicitly allows the Division to not address reimbursement disputes where payment is disallowed on the basis of medical necessity?

A No, but I see where it does.

Q See where what does? I'm sorry. I'm not following.

A It's not here, but it says the service has to be widely accepted. It doesn't say that the Division will make a determination. It doesn't say that here.

Q If I could refer you to Paragraph 7C --

A All right. I'm there.

Q In that paragraph, would you agree the statute says the Department must make a determination?

A Yes.

Q Under the proposed rule -- how does the proposed rule provide a determination of whether the carrier properly adjusted or disallowed payment?

A They are to be -- the Department is to be guided by the standards and policies set forth in the chapter. We do not determine experimental. We do not

determine research. We are unable to determine investigative.

Experimental is treatment in clinical-one trials, rats; clinical twos, working on humans and determining whether it's the proper dosage to a human. I mean, there's five levels of clinical, what we call, research. These are only done at statutory teaching research hospitals under an IRB board.

I have yet to see a dispute come in in that situation.

Q I hope not. I hope not.

In the -- let's see. Is it your understanding that the Office of the Judges of Compensation Claims has jurisdiction over reimbursement disputes where the carrier disallows payment on the basis of medical necessity?

A I do not know under- -- know much about the OJCCs, their offices. I know what we -- what we have a relationship with them regarding compensability, medical advisers. I'm certainly not an expert over there.

Q Do you believe that healthcare providers will be affected by the proposed rule stating that the Division will not address reimbursement disputes where the carrier disallows payment based on medical necessity or compensability?

A No.

Q And what's the basis for your -- for that belief?

A This rule, as it's written now -- the proposed rule impacts the Division. This is a rule process for dispute handling.

Q As a party to those disputes, don't you think how you handle the disputes will have an impact on the parties to the dispute and how that dispute gets resolved?

A This has to do with how the parties handle the dispute and not -- this has to do with their contracts between each other, and it also changes the way we do the dispute. It is entitled, "The reimbursement-dispute rule." This has to do with processing. It changes the time frames.

Q Do you believe that, under the proposed rule, when the Department issues a determination, and the carrier has disallowed one line item for medical necessity, but let's say there are other line items that have -- on which the Department makes a finding of underpayment or overpayment, whatever -- does the carrier, then, have to comply with that determination in its whole -- in whole; so, subtracting or adding all of the different line items to get to the total?

A The amount due -- the total correct amount due that is calculated by the Division would be all the line items that were appropriately paid or underpaid -- however you would like to look at it -- would be anything except the medical-necessity lines and the non-compensable lines. We're -- we can't make a decision on those. We do not have the authority to make those decisions.

Now, that amount is placed in what we call our payments-tabulation area. If they work out with the petitioner -- or the carrier for further payment, that is submitted to the Division, applied to the balance due, and that is paid in full. And that is based on our calculations of the fee-schedule amount.

Q Okay. We've talked about a number of reasons for the proposed rule. And again, I'm focusing on the proposed rule that says the Department will not address reimbursement disputes where the carrier disallows payment for medical necessity or for compensability.

Are there any reasons to support that rule that we haven't discussed today?

A I can think of reasons we wouldn't address a dispute, but that's not what we're talking about today.

(Examining document.) 38 might be one.

Q And when you refer to 38 --

A It's not real frequent. It's payment --

Q Are you --

A -- disallowed -- this is an EOBR Code -- insufficient documentation -- I'm sorry. 39. Forgive me -- payment disallowed, insufficient documentation; documentation does not support this medication was dispensed to the patient.

We also find this a lot in the hospitals where they've sent records in like this (indicating). And we do find it very often.

Q Okay. And are you saying that the proposed rule would provide a basis for the Department to not address a disallowance for Code 39?

A No. The Department would see that the carrier would use this EOBR. However, if the documentation does not support this, you would have a line item of leaning in the favor of the carrier, if there's no support.

If there's supportive documentation by the petitioner, then the evidence would point towards the petitioner. It's all based on substantiating documentation. It's just another frequent EOBR we've seen.

Q Okay. But it does not relate to the proposed rule.

A No, not a dash. How's that?

Q Okay. Great. Yeah. That's very -- that helps.

Are there any other testimony -- lines of testimony or opinions that you intend to offer at the hearing as a witness relating to this proposed rule?

THE WITNESS: I don't think so.

Do you have anything?

MS. PUMPHREY: Just for the record, no. That's pretty much it.

BY MS. DAILEY:

Q Okay. Are there any documents you intend to introduce as exhibits at the hearing that would explain or be a basis for your testimony?

A No.

Q When your team asks for documents to be produced relating to this rule challenge, what documents did you provide?

A E-mails, of course. Lots of e-mails. I think all of the iterations, if you would like to know, of this proposed rule, because I had a lot of that, and notes from rule workshops, and comments, and -- that's about it, I think.

Q Did that include all the files in your desk or in file folders relating to the proposed rule?

A File folders filed away in my file cabinet.

Q Okay. And so, you were involved in the drafting of the rule.

A Actually, yes, very much so.

Q What was your involvement?

A I began -- actually, this is a very long-standing project. Yeah, '09. And then it hit a space in there -- and I cannot pin the exact year that it went into limbo as -- or '09 was -- Anna Olsen was our program administrator. And we got an e-mail that said, ladies, good news, we may be able to open up 31. And we were all so happy because it was aging.

So, we all got -- all -- nurses, case managers got together and started just red-pen, red-pen, sticking stuff in. We met about every two months. Then it got to every month, and then it got to every week, trying to get this down.

And I was the person who typed, edited, put it all together, and then checked citations and got into statutes. When it was all culminated -- we had a new boss, Eric Lloyd. And I guess there were larger priorities because, at that point, it somehow went on the back burner and it took quite awhile.

In the interim, the new forms which are incorporated, the new petition form, and the new carrier response form had to be -- and it's DFS somehow -- you

have to create a form number. And so, that had to go downtown and be approved before we could proceed. That takes a while.

And then -- I can't tell you how long it took. We had another gap. And so, we picked it back up again and because EOBR codes changed and different things, we -- it got picked back up again.

And then when Theresa Pugh became our program administrator, she and Pam Macon, who was our bureau chief, really took charge of this and said, we've got to get this done, and just started sailing it with -- be pushing it, let's go, let's go. And I kept just staying on the board and saying, where is it, where is it. And here we are.

Q And when you say, this project, are you talking about changing the rule to address reimbursement contracts and managed-care arrangements or the rule to address medical necessity and compensability disputes?

A None of those two topics. Okay?

Q Okay.

A The issue came mostly on supporting documentation and how that would look.

At one point, we put some things in that they wouldn't let us put in.

Q Okay.

A You know, like when you send up six boxes of documents, how are we going to go through that? Is it indexed? Is it cataloged? What all do we really need, as well -- and that would be on both sides, petitioner and carrier and -- making the -- the whole process more efficient as well as clearer so that, when the carrier served documents on the petitioner, they wouldn't have to go through the same thing we're going through up here and the petitioner serving six boxes and off to having to serve those six boxes on the carrier. It became very burdensome in the administrative process.

So, it went through a lot of edits, which I kind of sent it to one, got it back, sent it to one, got it back. And then in the rule -- actual official rulemaking, I did the workshops. I was on the post-workshop edits and comments. The rule work- -- or are we on this workshop? I don't even know. It's been through twice.

Q Right.

A How's that? So, I'm somewhere along the range here.

Q Okay. And when, in your understanding, did the issue of reimbursement disputes involving medical necessity and compensability get added to the mix?

A I know the managed-care issue was repealed in,

is it, May, I think, of 2014.

Q But I'm -- I'm just focusing on medical necessity --

A Oh, from this.

Q -- and compensability.

A I don't know. I would have to look that up somewhere upstairs. I don't know. I think I have a timetable.

Q And do you know what drove that particular change in this rulemaking process that you're describing?

A Oh, yes, I do -- well, not drove it, but it had a -- an influence. We were seeing EOBR Code 10 being used, significantly used, when the carrier really meant medical necessity because we could find no evidence of a DWC-12. And we also had no EOBR for partial. So, we created 11, the partial.

Q Okay.

A And when we did the partial, that pulled way back on the 10s.

Q And so, the reason for the -- the proposed rule that -- the rule change we have, now -- it was still -- it was still related to the increase in the use of EOBR Code 10?

A No.

Q Okay.

A The EOBR Code 10 usage became less frequently and they began to use the partial code.

Q Okay.

A They didn't have that option before.

Q So, but what I was asking was, what was the reason that drove that change, the change that we're focusing on, the one --

A I don't know. That's a question or answer for Mr. Sabolic.

MS. DAILEY: Okay. All right. Well, that's all my questions.

THE WITNESS: Good.

MS. DAILEY: Ms. Pumphrey, do you have any?

MS. PUMPHREY: No, I don't.

MS. DAILEY: Ms. Hinson, do you have any?

MS. HINSON: No, thanks.

MS. DAILEY: Thank you, Ms. Metz.

THE WITNESS: Thank you, all.

(Whereupon, the deposition was concluded at 1:05 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 2nd day of October, 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 114, 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 2nd day of October, 2017.

ANDREA KOMARIDIS
NOTARY PUBLIC
COMMISSION #GG060963
EXPIRES FEBRUARY 09, 2021

ERRATA SHEET

I have read the transcript of my deposition, Pages 1 through 114 and hereby subscribe to same, including any corrections and/or amendments listed below.

DATE: _____ _____
LYNNE METZ

(FLORIDA SOCIETY OF AMBULATORY SURGICAL CENTERS ET AL V. DFS ET AL)

PAGE/LINE	CORRECTION/AMENDMENT	REASON FOR CHANGE

DATE OF DEPOSITION: September 18, 2017

REPORTER: ANDREA KOMARIDIS