STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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

Petitioners,

vs.

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

DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION,

Respondent,

and

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

Intervenors.
_____/

DEPOSITION OF:	ARLENE COTTON
AT THE INSTANCE OF:	Petitioners
DATE:	August 29, 2017
TIME:	Commenced: 1:00 p.m.
LOCATION:	Hartman Building 2012 Capital Circle Southeast Tallahassee, Florida
REPORTED BY:	DEBRA R. KRICK 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:

JENNIFER HINSON, ESQ.
Rutledge Ecenia, P.A.
119 South Monroe Street, Suite 202
Tallahassee, FL 32301

REPRESENTING AUTOMATED HEALTHCARE SOLUTIONS:

VIRGINIA DAILEY, ESQ.
Panza, Maurer & Maynard, P.A.
215 South Monroe Street, Suite 320
Tallahassee, FL 32301

REPRESENTING THE INTERVENORS:

DAVID R.TERRY, ESQ.
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Tallahassee, FL 32308

REPRESENTING THE DEPARTMENT OF FINANCIAL SERVICES:

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

ALSO APPEARING:
HELENE ROSEN
SAUL EPSTEIN

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NO.	DESCRIPTION	MARKED
	NONE MARKED	

*Huh-uh is a negative response
*Uh-huh is a positive response

D E P O S I T I O N

Whereupon,

ARLENE COTTON

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. DAILEY:

Q Ms. Cotton. My name is Virginia Dailey. I am one of the attorneys representing Automated Healthcare Solutions company in the rule challenge of the workers' comp rule, and we are focusing, and my questions will focus, on paragraph two of to the proposed rule. It's 31.016(2), and it relates to disputes where the carrier asserts that the injury is not compensable, or that the treatment is not medically necessary. Are you familiar with that proposed rule?

A Yes.

Q All right. Can you please state your name for the record?

A Arlene Cotton.

Q And can you state your address, your business address?

A No, I don't know what the address here is. It's Capital Circle Southeast, but I don't know what the

number is.

Q That's fine. And --

MS. PUMPHREY: It's 2012, I think.

BY MS. DAILEY:

Q I don't know. I believe it's 2012 Capital Circle Southeast, and that's fine.

What is the name -- the title of your position?

A I am an RN Consultant.

Q And how long have you been with the Department?

A 11 years.

Q And have you been in the Medical Services Section for all of those 11 years?

A Yes.

Q And you are aware that you are being deposed in this rule challenge case involving proposed rule 69L-31.016? Yes?

A Yes.

Q And have you ever been deposed before?

A Yes.

Q In the deposition, I am going to ask you a series of questions, and you will be answering those questions under oath. Do you understand that?

A Yes.

Q There are a few differences between a deposition and a typical conversation that I want to just go over with you.

First, our court reporter is going to transcribe everything that we say. In a normal conversation, we will interrupt one another, or talk over each other; but here it's very important that we wait for one another to finish speaking, asking a question or answering a question before the other one begins. Is that okay with you?

A Yes.

Q Second, because this is an oral transcription, the court reporter cannot indicate head nods or other gestures, so uh-huh and uh-uh, will get both of us in trouble, so please make sure all of your answers are verbal. Do you understand that?

A Yes.

Q Finally, unlike a typical conversation, your answers today are under oath, and that subjects you to potential criminal charges of perjury if you give false, misleading or incomplete testimony under oath. Do you understand that?

A Yes.

Q Is there any reason, such as being under unusual stress, a physical or mental condition, or being

under the influence of any substances that would prevent or limit you today from giving truthful answers to any questions?

A No.

Q If you don't understand a question, will you tell me or the person asking the question that you don't understand it?

A Yes.

Q And there is nothing wrong with asking me to repeat a question or to rephrase it, but if you answer my question, I will assume that you did understand the question, okay?

A Okay.

Q If you need clarification, you need to look at me for clarification and not to anyone else. Do you understand this?

A Yes.

Q Sometimes when I ask a question, you will have partial knowledge, but not absolute or certain or complete knowledge. For example, if I ask you the temperature right now, you couldn't necessarily tell me the exact degree, but you could probably give me an approximate answer. And even if you didn't know the number, you could say, it's really hot, it's really cold or it's somewhere in between. In that circumstance, an

answer of I don't know is not appropriate, but an answer giving a range or an estimate of your knowledge with an explanation is appropriate. Do you understand that?

A Yes.

Q Also, sometimes I might ask you a question where you are not sure of the answer, but you could find it by referencing a document and answering the question with certainty after referencing that document. So, for example, if I ask you the balance of your checking account on a particular date, you could ask to see your banking statement before you answered that question. We would then decide whether to show you the banking statement and get an exact response, or not look at that banking statement and go forward with a less exact response, an estimated response. Do you understand that?

A Yes.

Q I will not be asking questions about your banking account, though.

Also, I am entitled to what are considered complete answers in this proceeding. So that means an answer that fully and completely answers the question. So, for example, if you had orange juice, toast and coffee for breakfast and I asked you, what did you eat for breakfast, if you answered orange juice, that's not

a complete answer and you would not have properly answered the question. Now, you are also not under any obligation to tell me what you had for lunch, even if that's more interesting, but to focus on the question that was asked. Do you understand that?

A Yes.

Q Now, at any point, if you need to take what we have been calling a bio break, or a break for any time, just raise your hand and let us know, it's no problem.

A Okay.

Q Okay. Have you brought any documents with you in preparation for this deposition?

A No.

Q Did you review any documents before of this deposition in preparation?

A 440.

Q Chapter 440 of Florida Statutes?

A Yes.

Q Okay. When you prepared for the deposition, did you or your attorney review any other documents?

A No.

Q And did Chapter 440 refresh your memory?

A I only looked at 440.13, and, yes.

Q Okay. So it was 440, section 13?

A .13, yes.

Q Okay. Can you tell me your role in the Medical Services Section today?

A I review disputes, make a determination, issue a determination or a dismissal.

Q And how long have you performed that role in the Medical Services Section?

A 11 years.

Q So I want to focus on your time in the Medical Services Section before the proposed rule or the new policy relating to reimbursement disputes where the carrier asserts non-compensable or non-medical necessity. So I want to focus your attention to that point in time when the Department did determinations addressing those reimbursement disputes, do you recall that time period?

A We have never done compensability. We did at one point determine medical necessity.

Q Okay. So with respect to reimbursement disputes where the carrier asserted that the injury was not compensable, prior to the new policy, or proposed rule, what would the medical services section do with those reimbursement disputes?

A We would issue a determination saying that we cannot determine compensability, a Judge of Compensation Claims does that.

Q Are you aware, in your 11-year time period, of any reimbursement disputes where the Department did issue determinations where the carrier asserted non-compensability?

A With my disputes, no. I don't know about anyone else's.

Q Are you aware of any discussions within the Department about reimbursement disputes where the carrier asserts non-compensability as a basis for nonpayment, are you aware of any discussions within the Department about how to handle those disputes?

A We never handled them. I mean, that has always been our policy or procedure, not to determination compensability.

Q When the other RN case managers within the Medical Services Section team address reimbursement disputes, is there a time when you come together as a group to collaborate on those -- on cases?

A Yes.

Q Can you describe how that works?

A We have case manager meetings. We bring issues that are new, that we haven't seen before, or ones where a carrier has proposed something that we haven't come across before and we discuss it as a group.

Q In that setting of the case manager meetings,

has there ever been a discussion of reimbursement disputes where the carrier denies payment based on compensability?

A I don't remember.

Q With respect to reimbursement disputes involving compensability, it's my understanding that the Department adopted a policy sometime in the fall of 2016 that it will not address reimbursement disputes where the carrier asserts non-compensability, are you familiar with that policy?

A That has always been our process. We do not address compensability. Now, a statement came out, but I don't know when. It might have been in 2016, I am not sure, where we started adding that to our determinations; but it's always been our process that we don't address compensability.

Q We have information from one of your colleagues that there are at least two determinations where a carrier denied payment based on compensability and the Department, nevertheless, made a finding, or a determination, of improper payment even where the carrier had asserted non-compensability. Are you familiar with any instance where the Department has done that?

A I don't recall that.

MS. ROSEN: I apologize for interrupting. This is Helene Rosen. We can't hear anything on the phone. Is it possible to perhaps rearrange the seating or the box so that we could hear better?

MS. HINSON: Helene, this is in Jen. There is no way to move it any closer. This is the best it's going to be for the deposition.

ARLENE COTTON: We are unable to hear anything like we did for previous depos.

MS. DAILEY: Well, we are in the same room using the same equipment. We are set up slightly different. I think, perhaps, if I speak up and, perhaps, Ms. Cotton, if you and I both try to speak louder, that that may help. Let's try that. And Ms. Harnage has repositioned the phone.

MS. HARNAGE: Two inches more. Let's hope that works.

MS. HINSON: Thank you. Anything you could do would be helpful. We were able to hear Andrew's depo much clearer, so I am not sure if the same, you know, setup could be done as with Andrew's.

MS. DAILEY: Okay.

BY MS. DAILEY:

Q Ms. Cotton, going back to the new policy, do you know when, in the fall of 2016, that policy was

developed or changed?

MR. TERRY: Object to the characterization of policy change. What policy?

BY MS. DAILEY:

Q The policy with respect to the Department addressing determinations where the carrier asserts non-compensability, you stated that there was a new statement that came out. Do you know about when that was?

A No.

Q Okay. And do you know in what form that new statement came out? Was there an email, or a change to the template for determinations?

A It was added to the template.

Q And what template is that?

A It's our standard determination template. It's generated in ARAMIS.

Q And when you say ARAMIS, are you referencing the Department's database of reimbursement disputes?

A I don't know if that's what it's called.

Q Okay. Okay, but is the ARAMIS database the database that you and other members of the Medical Services Section team use to input the reimbursement disputes and then generate the reimbursement dispute determinations?

A Correct.

Q Thank you.

Okay. So now I would like to turn to reimbursement disputes where the carrier asserts non-medical necessity.

Prior to that new statement being added to the Department's standard determinations, how did the -- how did your team address reimbursement disputes when a carrier denied payment for medical necessity?

A It depended on what the basis of the medical necessity was for.

Q Can you tell me more about that?

A Okay. Let's say that a patient was in the hospital for a broken leg, they also had diabetes. We had some carriers that were using medical necessity to not reimburse for the medications for the diabetes. That's not medical necessity. You treat the patient as a whole. If they have diabetes and they are in the hospital, you treat the diabetes. You don't let them go into some sort of a coma simply because the hospital is not going to treat the diabetes because they have a broken leg. So we did have some carriers doing that.

Q And in that circumstance, the Department's determination would issue a finding of improper disallowance --

A Correct.

Q -- by the carrier, is that right?

A Correct.

Q And was that a standard practice when there were assertions by the carrier of medical necessity?

A To what?

Q To go ahead and issue a determination.

A It depended on what the medical necessity was for.

Q Did you feel that you have the medical expertise to answer the question of whether the treatment was medically necessary in these reimbursement disputes?

A Medical knowledge, yes. However, I am not a pee. I am a nurse. I am not an MD. And it would require a peer-to-peer to determine whether the medical doctor, because sometimes in the carrier response, you received an affidavit from a medical doctor who worked for the carrier saying this is not medically necessary, and we couldn't determine that because we are not a peer.

Q And in that instance, where you have, let's say, a letter of medical necessity from the health care provider, and then a letter of non-medical necessity from the carrier, and they are each from doctors, how

would the Department respond to that dispute?

A I don't personally remember having an affidavit on the provider side. The only ones I remember were from the carrier.

Q Okay. When you did have an affidavit from a doctor on the carr -- from the carrier, how did the Department resolve those reimbursement disputes?

A We did not award payment for those -- for those particular line items. It wasn't the whole bill usually. It was just line items.

Q So you were able to issue a determination even though you did not have peer-to-peer review of the carrier's response?

A For what scenario?

Q The same scenario you were just describing, where you have a carrier who's provided an affidavit from a doctor that the treatment is not medically necessary.

A We always issue either a determination or a dismissal on all cases that come in.

Q I see.

A So those line items that were deemed not medically necessary by the carrier's MD, we would not award reimbursement.

Q I am trying to understand what you said

earlier about the fact that you have medical knowledge, but that where you have an affidavit from a medical doctor, that you are not a peer of that medical doctor and can't do peer-to-peer review.

A Correct.

Q So what is the piece of that reimbursement dispute process that's missing?

A I don't have an MD behind my name. I have an RN.

Q And, in your opinion, did that make it a hardship or difficult to render these determinations?

A No.

Q Was there any lack of expertise or subject matter expertise that would have helped in rendering determinations when a carrier disallowed payment based on medical necessity?

A In what scenario?

Q So in a reimbursement dispute, let's say a health care provider has provided the treatment, prescribed medication, dispensed medication, the carrier has now denied payment for medical necessity --

A The whole bill or just line items?

Q The line items in question --

A Okay.

Q -- the prescribed medication in question, and

then a reimbursement dispute is submitted to the Department. Did you and your team have sufficient expertise to address those denials of medical necessity?

A And there was not a carrier response?

Q There was a carrier response.

A And did the carrier response also have a affidavit from some medical doctor as to the medical necessity attached?

Q Well, let's take that in both parts. Let's say one, in the first instance, yes, they did, and in the second instance they didn't, how would the Department handle that?

A If they had an MD who issued their affidavit saying that these items were not medically necessary, then we would not award them. If we had a carrier response where they just said, no, we don't agree with this, then we would make a determination, as in the diabetic medications, that, yes, you treat the entire patient, not just the broken leg.

Q Some of your colleagues have indicated that one of the reasons for the change to the policy with respect to reimbursement disputes where the carrier denies payment for medical necessity was a lack of subject matter expertise within the Medical Services Section. Have you heard that concern before?

A Not where I am concerned.

Q Have you heard anyone within the Department raise that concern?

A Not that I remember.

Q After the new statement was added to the Department's template for determinations, how does the Department treat a reimbursement dispute where a carrier denies payment based on medical necessity?

A We do not award.

Q In your 11 years in the Medical Services Section, have you ever requested the involvement of an expert medical adviser in a reimbursement dispute?

A No.

Q Do you have the authority to do that?

A Not to my knowledge.

Q Are you aware of anyone within the Medical Services Section who has requested the involvement of an expert medical adviser in a reimbursement dispute?

A In utilization review they have, but not as far as a dispute is concerned, that I am aware of.

Q Do you know under what circumstances an expert medical adviser would be available to you or others in the Medical Services Section?

A The only time I know of is with utilization review.

Q And who makes the determination of when an expert medical adviser can be used, or involved?

A That would be management.

Q And who is that management?

A Anybody in senior management. There is a cost involved. They have to find someone who is in that particular field.

Q And when you say management, are you talking about the Division of Workers' Comp Director, Mr. Holloman? Are you talking about somebody at the Medical Services Section level? What level of management would be involved in that decision?

A Well, it would probably go to Theresa, who would then go to Charlene, who would probably go to Andrew. I don't know if Tanner is involved or not.

Q In your training from the Department, are you given any training or guidance about the use of expert medical advisers in reimbursement disputes?

A No.

Q Do you know when that new statement was added to the Department's template for determinations? Do you know where I am -- what I am referencing?

A Yes.

Q So when that new statement was added, do you know what the reasons for that adding of that new

statement were?

A I was not involved in those meetings.

Q Were any reasons ever communicated to you or your team?

A I don't remember if they were.

Q Do you remember hearing anything within the Department about what those reasons might be?

A For adding the -- I don't remember.

Q Are you aware of any problems or difficulties that existed in the reimbursement dispute process before that new policy was adopted?

A Concerning what?

Q Either compensability or medical necessity.

A Compensability, there wouldn't be because we did not address it. Medical necessity I am not sure of.

Q Who would have been involved in that issue within the Department regarding medical necessity and how to handle reimbursement disputes where the carrier denies payment for medical necessity?

A I would assume management, but I wouldn't know who because I wasn't involved in it.

Q When you mentioned earlier the issue of not having an MD, a peer review when you have a carrier response with an affidavit from a doctor and an RN analyzing the reimbursement dispute, would the

involvement of an EMA, or expert medical adviser, give you that peer-to-peer review by involving a doctor or on behalf of the Department?

A It probably would.

Q Are you aware of any other categories or types of reimbursement disputes where the Department has discussed that problems exist, or there is uncertainty in rendering determinations?

A I am not sure I understand your question.

Q Sure. So it seems there were -- the reimbursement disputes where carriers denied payment for medical necessity was a category of reimbursement disputes where the Department was having concerns about rendering determinations. Were there any other categories of reimbursement disputes where there were similar concerns about rendering determinations?

A What concerns? You have to be a little bit more precise.

Q Sure. So the concern that I was referencing is what you and I talked about earlier, about not having the peer level expertise. So you have -- in an instance when you have a medical doctor's affidavit in a reimbursement dispute, and the Department's representative does not have an MD, there is an imbalance in credentials; would you agree with that?

A Uh-huh.

Q In that instance, does it make it harder to render a determination when there is an imbalance of credentials?

A No.

Q Are there instances when the provider included documentation from a medical doctor as well as the carrier providing information from a medical doctor?

A Not that I can remember.

Q Using as an example a hypothetical reimbursement dispute where, let's say, we have a broken leg. The provider provides -- prescribes medication and dispense is that medication. The carrier denies payment for that medication based on medical necessity. And in the reimbursement dispute, the petitioner, or the health care provider gives you a letter of medical necessity signed by the doctor, and the carrier gives you a letter from their doctor. In that instance, is there an imbalance of credentials in reviewing the reimbursement dispute?

MS. HARNAGE: Form.

BY MS. DAILEY:

Q Go ahead. You can answer.

A It's doc to doc.

Q And in that instance, what would the

Department's determination be prior to this new rule being adopted?

MS. PUMPHREY: Calls for speculation.

MR. TERRY: Object.

THE WITNESS: That I don't know. I personally would have taken it to my supervisor and said, what am I supposed to do?

BY MS. DAILEY:

Q Can you point to any language in Section 440.13 that you referenced earlier that allows the Division to not address reimbursement disputes where the carrier disallows payment based on medical necessity or compensability?

A No. Nor can I point to anyplace that it tells us to address it.

Q And under the new policy, you stated earlier that the Department will not award payment, is that correct?

A (Witness nods head in the affirmative.)

Q So it's your understanding that under the new policy, or proposed rule, the Department's determination essentially affirms the carrier's disallowance, or denial of payment?

MS. HARNAGE: Form.

THE WITNESS: It doesn't affirm or disaffirm.

It just states that we are not going to address it.

BY MS. DAILEY:

Q And in a reimbursement dispute determination when the -- under the new policy, the determination includes a dash in the line item where the carrier has denied payment for medical necessity or compensability. Is it your understanding the dash -- what -- what is your understanding of what that dash means?

A The dash also refers to a little note down on the bottom saying that the Division does not address compensability or medical necessity.

Q And what is the result of that determination to the provider? Do they get paid by the carrier?

A For the balance?

Q For the line item that has a dash.

A I have no idea.

Q Is it your understanding that the carrier is obligated to pay the provider for the line item when the Department's determination includes a dash in that item?

MR. TERRY: Objection, asked and answered.

THE WITNESS: Again, what the carrier does or doesn't do doesn't have anything to do with the division at that point.

BY MS. DAILEY:

Q Can you describe how the process for

reimbursement disputes involving medical necessity, how the process is different now than it was before that statement was added to the Department's template?

A Before, we would review the records as to whether or not we thought, like in the scenario I gave you with the broken leg and the diabetes, whether it was part and parcel with taking care of the entire individual or not. Now we do not do that.

Q And when the Department does not do that type of review, what is the result to the provider?

MR. TERRY: Objection, asked and answered.

THE WITNESS: Again, we make a determination as to what we can determine.

BY MS. DAILEY:

Q Under the new policy, what steps do you take when a reimbursement dispute comes before you? What steps do you take to assess the validity of the carrier's assertion of non-medical necessity?

A We don't. If it's coded as not medically necessary, we do not address it.

Q If this proposed rule is adopted and becomes final and effective. What are the limits that would constrain carriers from asserting medical necessity as a basis for denial even where such assertion is unfounded if the Department won't check?

MR. TERRY: Objection, speculation.

MS. HARNAGE: We'll join that, and form.

BY MS. DAILEY:

Q You can go ahead.

A I have no idea.

Q Will there be any steps that the Department will take to check on the carrier's assertion that a treatment is not medically necessary?

A I can't answer that. I don't know what management will or will not do.

Q Do you believe there should be such checks on the carrier's assertion of non-compensability or medical necessity?

MR. TERRY: Objection, relevance.

MS. HARNAGE: Form.

THE WITNESS: I believe Monitoring and Auditing does do checks on all sorts of things, but I don't know what all they do check.

BY MS. DAILEY:

Q Do you know who within the Medical Services Section looks for a trend, or a pattern in reimbursement disputes?

A We load information into ARAMIS. Reports are generated from ARAMIS, and then management looks at those from there.

Q And when you say management looks at those, who would that management team be?

A Again, I don't know. I know Von generates the reports, but where they go from there, I don't know.

Q When you say Von, are you referencing Ms. Bozman?

A Yes.

Q Under the proposed rule, or the new policy, how does the Division handle the failure of a carrier to respond to a petition for resolution of reimbursement dispute?

MS. HARNAGE: Form, incomplete hypothetical. You can answer.

BY MS. DAILEY:

Q Go ahead.

A Where there is money to be awarded the petitioner, is that what you are talking about?

Q Yes. So where there is a petitioner that has submitted a reimbursement dispute, and the -- let's say the EOBR Code includes disallowance of payment for a line item based on medical necessity, but the carrier does not respond to the petition for reimbursement determination, how does the Department handle those reimbursement disputes?

A We have to issue a determination or a

dismissal on all disputes that come in. So if a determination is warranted, we go ahead and do a determination whether the carrier has responded within their 30 days or not.

Q Okay. So what I am trying to understand is, does the carrier need to respond, file its own response to deny medical necessity, or is it sufficient to have -- for the carrier to have included an EOBR Code denying medical necessity in the EOBR to the provider?

A The EOBR to the provider lets the provider know the reasons for disallowance or payment of line items. So, in essence, the carrier is telling them at that point, we are not paying you because of this, or we are going to pay you because of whatever the code is that they use. So that is the form that the carrier allows -- tells the provider what pertains to the reimbursement.

Q Okay. So then, if the carrier submits the EOBR, which includes a code -- and I think it's 22, 23, 24 -- for disallowing payment for medical necessity, is that enough, then, for the Department, when you review that reimbursement dispute, to not address that line item?

A Correct.

Q Okay. So that policy would apply even where

the carrier fails to respond at all to the petition --

A Issues a carrier response?

Q -- correct?

A Yes, because the EOBR is the document wherein they notify the petitioner whether they are paying, or disallowing, or adjusting.

Q Okay. In the proposed rule, the language says, the health care provider must demonstrate authorization for treatment from the carrier. Can you describe what is the documentation that would demonstrate authorization for treatment?

A It varies. Sometimes we have telephone calls. Sometimes we have FAXes. Every once in a while we get an email that's included in with the petition.

Q And what is the scope of that authorization typically that you see in these reimbursement disputes?

A What do you mean by scope?

Q Does it say what medical prescriptions or treatments are authorized or not authorized?

A It usually just gives a code for authorization. Sometimes there is a letter included stating that when you submit the bill, you need to have dah, dah, dah, dah, dah, dah, dah attached to it. I think I have seen one in my cases where they have time-limited the stay, and that's usually in a letter as

well, at least for my case it was a letter. But most of them are just notes put in from telephone calls, spoke with so and so at so and so, and they gave authorization number dah, dah, dah, dah.

Q Thanks.

Do you believe that health care providers will be affected by this new policy or new rule that we've been talking about?

MR. TERRY: Objection, relevance.

MS. PUMPHREY: Calls for speculation.

THE WITNESS: I don't know how.

BY MS. DAILEY:

Q Can you explain that?

A Well, we've been applying it for about two years now, I guess, and nobody has objected so far.

Q Are you aware of my client's letters and public comments in the rule-making proceedings about this proposed rule?

A No, I am not part of the manual procedure.

Q When you say the manual procedure, what does that refer to?

A We have people who work on the manuals, who produce the new language, who go to the workshops, who submit the documentation.

Q So is it fair to say you would not know if

providers have, in fact, objected to the new policy or new rule?

A Not unless somebody just stuck their head in my office and told me about it.

Q Okay. And did anybody stick their head in your office and tell you?

A Not that I am aware of.

Q Is it your understanding that health care providers must comply with the proposed rule?

MS. HARNAGE: Form.

THE WITNESS: That's what the rule is.

BY MS. DAILEY:

Q What do you mean?

A Complying to the rule is what we do. If you have a dispute, we apply the rule.

Q What is your experience about the documentation of authorization for treatment in reimbursement disputes? In your 11 years, have you seen that authorization is missing in reimbursement disputes? Is it --

A Occasionally, yes.

Q And is there an EOBR Code that addresses lack of authorization directly?

A Oh, there probably is, but I would have to look at them.

Q Is that a basis for disallowance of payment that you often see in these reimbursement disputes?

A No.

Q Okay. I just want to go back to the -- an issue we talked about earlier.

Are there any reimbursement disputes that you felt unable to determine or decide based on your expertise in comparison to the information submitted by the provider or the carrier?

A Are you asking me if I can make a determination if parts of a file are missing that are necessary to make the determination, is that what you are asking me?

Q Well, let's take that -- let's take that up first.

If there are parts missing, I would assume you would refer that reimbursement dispute back to the parties, and either dismiss it or notice a deficiency.

A No, you assumed wrong.

Q Okay.

A And NOD is only issued for those things that we have to have to make a determination. We do not make the case for either the provider or the carrier. It is up to them to substantiate their claims. If they don't, then we can't make a determination on that particular

line item.

Q And what is the documentation that would typically be required for a provider to substantiate its claim on a line item if the carrier disallows payment for medical necessity?

MR. TERRY: Objection, asked and answered.

THE WITNESS: They would have to provide or substantiate the medical necessity.

BY MS. DAILEY:

Q And what would that documentation look like?

A I have no idea. That would be up to the provider.

Q Before the new policy was put in place, what documentation would providers typically include to support medical necessity?

A Okay, going back to the scenario of the broken leg and the diabetes, they would need to provide documentation that the person was getting the medical treatment for the diabetes that they did have, because you treat the entire patient, not just the leg.

Q And would that be a letter of medical necessity or some other kind of documentation?

A Before the statement was entered into, where we don't address it, that would be sufficient.

Q Okay. So that addresses the situation where

there is information missing, and you don't feel that you have enough information to make a decision, is that right, what we've just talked about?

A No. What we just talked about was that I had all the information and I could determine that, yes, they are treating the entire individual, not just a leg.

Now, the scenario you just said, where I could not make a determination, would be they didn't give me any records.

Q The provider did not provide --

A The records.

Q -- the medical records?

A Correct.

Q That certainly makes sense. You can't make a determination if they don't give you the information on which to make a determination.

I guess my question, though, was, before the new policy was put in place, was there a situation where there were reimbursement disputes where the Department didn't have the expertise necessary to make a judgment call and decide between the provider's assertion that the treatment was medically necessary and the carrier's response that it was not medically necessary?

A What kind of response? Are we talking about only on the EOBR and there is no carrier response to the

dispute, or are we talking where it's on the EOBR and the carrier substantiates that disallowance in their reimbursement dispute response?

Q I am asking about the time period before the new policy was in place.

A I am also doing the same thing, so --

Q And so I guess I am -- I don't know. Was that a difference in how the Department would resolve those reimbursement disputes? Did it matter whether it was in the EOBR versus a carrier response?

A It would have to be in the EOBR, because, as I have stated before, the EOBR is the document that's used to tell a provider whether there is an allowance, a disallowance or an adjustment, okay. So you would have to have on the EOBR. If there was not a carrier response at all, the carrier never responded, then we would look at what the provider gave us, period.

Okay. Let's say that the carrier did respond and, in their response, they say, look, our doc says, X, Y, Z, then we would take that into consideration.

Q And before the new rule was in place, if the provider gave you a letter of medical necessity that the prescribed medication was medically necessary, and the carrier gave you an EOBR Code that it was disallowing based on medical necessity but not a carrier response,

how did the Department resolve the dispute in that instance?

A If the provider had substantiated their position, then we would award it for them. And without a carrier response, we have no idea what the carrier was thinking, or why they did that particular action.

Q And in that instance, you would have awarded payment?

A It depends on what we found in the records.

Q Okay.

A It's sort of hard to answer that one since I don't have anything in front of me.

Q Sure.

Do you intend to appear as a witness at the hearing in this rule challenge?

A I believe that's what I am down as.

Q Okay. Are there any areas or reasons for the new rule that we haven't discussed today that you intend to offer or discuss at the hearing?

A I have no idea because I don't know what we intend to do.

Q Okay. Have we discussed all of the reasons that you support the proposed rule that the Division will not address reimbursement disputes where the carrier disallows payment on the basis of medical

necessity or compensability?

A Such as?

Q Well, that is the language of the proposed rule. I am asking what are the reasons for that rule, and have we discussed all of those reasons that you would feel comfortable talking about?

A Yes.

MS. DAILEY: Okay. I think that's all the question I have at this time.

We can go off the record.

(Discussion off the record.).

EXAMINATION

BY MS. HINSON:

Q Ms. Cotton, my name is Jennifer Hinson, and I represent Oak Hill Hospital and Parallon Business Performance Group. And our position in this litigation is regarding paragraph one of the rule that Ms. Dailey was just talking to you about. And that rule is 69L-31.016. And that's the reimbursement dispute rule involving a contract or a managed care arrangement.

With your attorney's permission, I am going to hand you a copy of the rule. I have noted paragraph one, and it might benefit you for the sake of our discussion this afternoon to take a quick look at it.

A Okay.

Q Okay. And before we dive right in, I just have a few preliminary questions for you.

What is your level of education?

A I have a Master's in Nursing.

Q And when did you obtain that degree?

A '93 or '94, I think.

Q Okay. Do you have any other professional certifications?

A I have a lot of certifications.

Q Okay. And what are those?

A I have certifications of case management, bioterrorism, disaster, a lot of them. I can't even begin to name them all.

Q Okay. Well, what about coding?

A At one time, the Division had us become coders, but I let it lapse. The agreement was they would pay for the yearly fee and we would keep up the CEs, and then the Department said they weren't going to pay for it anymore, and so I said, okay.

Q Got it.

How long were you certified in coding, approximately?

A I think it was two years.

Q And about when was that?

A Eight, nine, 10 years ago. Somewhere in

there.

Q Do you know if anyone else in the Medical Services Section is certified in coding?

A Now or then?

Q Now. Now.

A I believe Judy is, and I believe Valeria is.

Q And were there others that used to be certified that you know of?

A All the nurses were, and I think all of us let it lapse, but you would have to ask them.

Q Okay. And who do you report to?

A Theresa Pugh.

Q And how many other members are on your team or in the Medical Services Section?

A Nurses? There are three other nurses.

Q And who are they?

A That would be Lynn Metz, Welby Cox-Myers and Marcia.

Q Okay. What's Marcia's last name?

A I am trying to think.

Q Okay.

A That's terrible, I work with them every day. Paulk.

Q Paulk?

A Paulk.

Q P-A-L-K?

A P-A-U-L-K.

Q Okay. And I know you said you have been here 11 years. When you came onboard and, I guess through the current time, do you have any internal training that you get through the Division here?

A When I first came on, I was trained in how to do disputes. As far as additional training in doing disputes, no, just as different things changed, we were notified of the changes as rules changed, or policy changed, or procedure changed.

Q Okay. I am going to move on now to the Agency's statement of estimated regulatory costs. Are you familiar with that?

A No.

Q Okay. Then is it safe to say that you are not involved in the process of evaluating and formulating the Agency's, what we call SERC?

A Nope.

Q Okay. Yes, it's fair to say that you weren't?

A I am not involved.

Q Okay. Do you know why the Division stopped making determinations when a reimbursement contract or a managed care arrangement was alleged?

A When I first came onboard, we immediately

dismissed managed care. The Agency for Health Care Administration determines their rules and regulations, not workers' comp.

Q But it's my understanding, then, that it went from immediately dismissing to a time period when you did, in fact, make determinations only when a reimbursement contract or managed care arrangement was alleged; is that correct?

A When we started doing managed care was to state that there was a managed care, but according to our rule, this is what it would be. And if there is a managed care, then you would have to deal with the Agency for Health Care Administration on that. We have no jurisdiction over managed care.

Q So I know the Agency's position on that, but there are determinations out there -- and I can pull one here from my files -- where a health care provider submitted a disputed reimbursement petition, and both parties agreed that either a reimbursement contract or a managed care arrangement was involved, they provided the rates that were negotiated in those documents, and then the Agency took those rates and applied them and made a determination as to whether or not the carrier had properly paid the claim.

A Not on managed care.

Q Okay.

A We did not address managed care. It is the Agency for Health Care Administration's jurisdiction. When we were told to start looking at managed care and not dismissing them, we only applied our rule. And there is a statement in there that states that if it is a contract or managed care, then they would need to follow that particular type of contract.

Q Okay. So it seems to me that you are making a distinction between a managed care arrangement and a reimbursement contract, is that a distinction you are trying to make right now?

A There is a definite distinction.

Q I understand that. I certainly understand that.

A Managed care is not our jurisdiction. It is AHCA's. They make the rules. They do the regulations. We have nothing do with that.

Q Does AHCA make reimbursement dispute determinations if managed care is alleged, that you know of?

A I have no idea what AHCA does. I don't work for AHCA. You would need to discuss that with them.

Q Thanks. I am going to find one of those determinations and ask you about it. Maybe that will

help clear it up.

MS. HINSON: Okay. What I am going to give the deponent is attachment to the Florida Society of Ambulatory Surgical Centers' petition that they filed in this case. And it is an example of a written determination that was made by the Division before the Department instituted the policy that's set forth in the proposed rule.

MS. PUMPHREY: Is it a contract or managed care?

MS. HINSON: Well, it doesn't say. What it says is -- it references the Rockport contract. But I think sometimes, you know, managed care arrangement and whatnot is used interchangeably.

MS. PUMPHREY: Can we go off the record a minute?

(Discussion off the record.)

BY MS. HINSON:

Q Before we move on, and before I give you this document, the rule that I gave you earlier refers to the Agency's policy in how it's going to handle reimbursement disputes when there is an assertion that there is a contract between the carrier and the provider that establishes the amount of reimbursement, or where the carrier provided health care services to an injured

worker through a workers' comp managed care arrangement.

A Pursuant to Section 440.134.

Q Right. So those are two different -- let me ask you, are those two different scenarios to you?

A Yes, because Section 440.134 refers to the Agency for Health Care Administration and managed care contracts. Do you have -- do you have 440, and I will be happy to give it to you.

Q No. No. I have it, and I am very familiar with it. The distinction you were making between the contract and the managed care arrangement is what I was misunderstanding. I wasn't understanding you clearly.

So do you know why the Agency stopped making determinations when a reimbursement contract was alleged?

A I believe -- and this is just what I was told -- that it was determined that we really didn't have jurisdiction over contracts that we were not a party to.

Q And are you saying that's your understanding as to why the Agency stopped?

A Yes.

Q Okay. Then it sounds like that's the reason they stopped on the managed care arrangements as well, is that your testimony?

A Workers' comp has never been part of managed care. That is the Agency for Health Care Administration's jurisdiction.

Q The questions I am going to ask you at this point are going to pertain just to the scenario where a reimbursement contract is alleged.

Can you explain the dispute resolution process from an internal perspective before the Agency implemented their policy and did not consider the terms of a reimbursement contract? So asked more directly, back in the day when you would consider the terms of a reimbursement contract, can you explain what your internal process was when you would get such a dispute?

A The dispute would come in from the provider, and they would state they have a contract, and they would provide the portions of the contract that applied to workers' comp. If there was a carrier response, and the carrier agreed, then we would apply the terms of the contract to the dispute.

Q Okay. And what did that entail?

A I don't understand the question.

Q Well, you would apply the rates, so you would take the rates and do a calculation, or what -- what all did that entail when you were applying the rates?

A Okay. If the contract, let's say, was a

really simple one, and it was, say, 10 percent off of the workers' comp rate, then we would go ahead and work from there, determine would what it would be by our rule and then subtract 10 percent.

Q Okay. And did that pose any difficulties for you if that was --

A A simple scenario, no. The problems occurred when we got involved contracts. The if whens or sometimes contracts. And sometimes they were so involved that we even had the provider say, we don't understand this contract, can you figure it out? I mean, we've actually had that.

Q Who would say that?

A Oh, the provider.

Q Oh, the provider.

A Then we would have the carrier, and the carrier wouldn't have the same contract. That's when problems started occurring. That's when we would go down to legal and we would say, so what do we do? We've got two different contracts.

Then we started getting multiple contracts on the carrier's side, and they wanted to apply all of them. And then, again, we would go back to legal and we would say, what are we supposed to do with this?

The really simple contracts were not a

problem. It's the ones where the carrier and the provider didn't agree, or they were so involved that we had to get legal involved to determine what in the world they were saying.

Q Okay. And are you able to estimate for me what percentage would fall into the simple category that you spoke of and what percentage would fall into the more complicated?

A No. That was way too many years ago.

Q Okay. Can you tell me whether the simple ones were outnumbered, the more complex ones, or versa-versa?

A When I first started, there were more of the simple ones, and then things became progressively more difficult. We still had some contracts that were simple being sent in, but they became more involved.

Q Do you know whether this was one of the reasons that the Agency decided to change their policy?

A I don't know.

Q And let's go back to the managed care arrangements for a moment.

Did you testify that the Division has never, when a managed care arrangement has been alleged, applied the terms of that arrangement to a reimbursement dispute determination, that you know of?

A I can't speak to the Division. I can speak to

my own cases --

Q Okay.

A -- that, no, unless I was directed, and I can't remember any of them where I was actually districted to work them, I did not work them.

Q And do you know of anybody else in the division that worked those types of cases that way?

A I have no knowledge of what other people do.

Q And since the Agency has implemented this new policy where they don't consider the reimbursement contract terms, have you seen any impact on your day-to-day work as a result of that?

A I am not going down to legal as much.

Q Now, I do think I have a descent grasp on the difficulties that you described with the reimbursement contracts, how some were fairly convoluted and not direct, and then, of course, getting a bunch of different contracts potentially from the carrier.

Those challenges that you would have, when that would happen, I mean, could that be remedied by having a place on a petition form that required the parties to specify the reimbursement rates that apply to each line item, you know, that's listed in the dispute?

A How would that help? If you have a three-page UB-04, and they have to specify on each line item what

the rate would be, that's additional work, not only on the petitioner and on the carrier, but on us; because now we are looking to see, oh, this line applies to this contract, this line applies to that contract.

Q Well, it might not be that hard. I mean, it might be that, of the hundred lines, 50 are reimbursed at X rate and 50 are reimbursed at another rate, right? It wouldn't necessarily be that convoluted.

A But that's still going to require more work on everybody's part.

Q Fair enough. That's fair.

But if you had a petition form where the carrier and the provider said, this is the rate that applies to this line item, this line item, this line item, would that help eliminate or mitigate the confusion and the difficulties that you testified to?

A But if the carrier and the provider agreed, then there wouldn't be a dispute. The dispute comes about because they don't agree.

Q On how to apply the contract?

A On the reimbursement amount. I am not looking at contracts. I am looking at the reimbursement, where the reimbursement amount was correct according to our rule.

Q Right.

A Not according to the contract, according to our rule, because that is what we go by.

Q Your rule --

A Our rule.

Q -- your proposed rule, right. Right.

A No, our actual rule.

Q Oh.

A We actually have manuals that tell you how to reimburse.

Q Yeah. And you know, those manuals -- let me pull one for you, because I do have questions. We might as well go ahead and address those now.

When I was looking at the manual, I noticed, gosh, in probably 20 or more places, that the reimbursement manual says that the carrier will reimburse a health care provider either the MRA or a mutually agreed upon contract price.

So I do understand the Agency's reliance on the manual. What I don't understand is why the Agency doesn't consider the mutually agreed upon contract price, because that is the language in the manual. Do you know why?

A If you look at 440, it says that by our schedule of reimbursement or contract. We cannot tell a provider how they can do business. If they want to

enter into a contract, that's between the provider and whomever. It's not the State's responsibility to tell them how to do their business. We can tell them what reimbursement is for workers' comp according to our rule, and that is what we apply.

Q Right, but reimbursement for workers' comp under this manual is either the MRA or the mutually agreed upon contract price.

A I don't know what you are asking me.

Q Well, I am asking you, if you are following the manual when you make these determinations, and the manual says it's the MRA or agreed upon contract price, why are you only considering the MRA, and why are you not considering this additional language that's in your manual?

A Are we part of that contract?

Q It doesn't make a distinction in the manual. Are you a part of determining the MRA?

A Yes.

Q I thought that was the three-member panel.

A There is a group who determine, get together, besides the three-member panel, they are the final ones. But there is a long process as to what the MRAs are going to be, and there is quite a few people that are involved in that before it ever goes to the three-member

panel.

Q Okay. We could probably go back and forth for a while, so let me just ask you one question and then we can move on.

Do you know why the Agency has chosen to not consider the terms of the reimbursement manual that say a mutually agreed upon contract price?

MR. TERRY: Objection, asked and answered.

THE WITNESS: 440 states, by our schedule of reimbursement or contract. So in our manual, we make sure that the provider knows that they can have a contract. So I still don't understand your contusion.

BY MS. HINSON:

Q Okay. Well, my confusion is that --

MS. PUMPHREY: Would you like me to pass a copy of this --

MS. HINSON: Yeah, why don't we pass that copy.

BY MS. HINSON:

Q It's referenced several times, but you will see it right at the bottom of page 15 there. The bottom section in bold says, Florida health care providers, and then if you look at that middle paragraph --

A It's through all the -- it's through all the

different be manuals. That's a statement saying that you are going to be either reimbursed by the MRA or by your contract, but we can only determine the MRA.

Q Okay. Where does it say that, either in the manual or in the statute?

A Where does it say in the statute that we have do otherwise?

Q No, I am asking you a question, though. Where does it say in the statute that you can make that distinction?

A Where does it say that we have to do a contract?

Q I am asking -- hold on --

A Our 440 says that we are to apply the three members' determination of reimbursement.

Q No, the statute says that the Agency has exclusive jurisdiction to decide any matters regarding reimbursement, and it also defines reimbursement dispute as any disagreement between a provider and a workers' comp carrier with regard to reimbursement.

A This sounds like a legal discussion.

MS. HARNAGE: I am sorry -- hold on. Hold on, what's the question?

MS. HINSON: Well, I am going to have to have her read it back now. I don't remember.

Could you read it back?

(Whereupon, the court reporter read the requested portion of the record.)

BY MS. HINSON:

Q So where does it say in the statute that you only have to consider the MRA, and that you are not allowed to consider the mutually agreed upon contract price? And I have a copy of the statute if you would like to take a look at it.

A But I don't know where in the statute that it says we have to look at a contract.

Q I just need you to answer my question, and it's yes, no, or I don't know.

A I don't know.

Q Okay. That's fair.

Let's stick on the manual for a minute. When I was looking through it, I noticed that the home health agency services section seems --

A You are in the health care provider manual now?

Q Yes, ma'am.

A All right.

Q And that's the same one that's in front of you.

A Okay.

Q Yeah, and so the home health -- go to page 33, if you don't mind. That includes some of the home health agency services. And if you go down on page 33 to the section that says reimbursement in bold. It says, the carrier reimburses the home health agency at an amount that's mutually agreed upon in a contract. Do you see that?

A Yes.

Q Okay. So is it safe to say, then, that there is no MRA for home health services?

A No, there is not.

Q Okay. So under the current policy, where you don't apply contract terms, what does a home health agency do -- well, let me ask this: If a home health agency files a petition for reimbursement dispute, what does the Agency do with it?

A I haven't had one, so I don't know.

Q Okay.

A In 11 years, I have not had a home agency submit something with a contract and say, we didn't get paid.

Q Okay. I suspect it's probably not a very common service in workers' comp. Okay, that's fair.

Do you know of anybody else that you work with that has ever had a home health agency reimbursement

dispute?

A Not that I know of.

Q Okay. Have you heard anyone in the Agency, either here at the Division or at any other DFS office, express any concerns about the legality of the rule that we are talking about?

A No.

Q Okay. I am going to give you a copy of 440.13. I have a few questions about subparagraph (7). Just let me know when you have had a chance to take a look at that, Ms. Cotton.

A At what part of it?

Q Seven.

A All of seven?

Q Yes.

A Okay.

Q It's just half a page.

A Okay.

Q Okay. Let's start with paragraph C. And paragraph C says, the Department must provide to the petitioner, the carrier and affected parties a written determination of whether the carrier properly adjusted or disallowed payment. Do you see that?

A Yes.

Q Do you believe that the determinations that

you make currently when a reimbursement contract is alleged determine whether the carrier has properly adjusted or disallowed payment?

A Yes, we apply our rule.

Q Okay. Well, explain to me why you think your current determinations determine whether the carrier properly adjusted or disallowed payment to the health care provider.

A The Department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters and protocols of treatment in reaching our reimbursement. We apply our reimbursement schedule.

Q Okay. I understand that you apply your reimbursement schedule, and I understand that it's the Agency's position that you make a written determination. What I don't see in the determinations is a statement as to whether the carrier properly adjusted or disallowed payment to the health care provider.

So I am asking you -- I know you do all the other things. For the sake of this conversation, I know you do all the other things. Do you make that determination as to whether they've properly adjusted or disallowed payment to the provider?

A Pursuant to our schedule, yes.

Q Okay.

A We give them an amount stating, per our schedule, this is the amount that is due.

Q But how does that determine whether, in the case at hand, the carrier properly adjusted or disallowed payment?

A I don't understand your question.

Q Well, if there is a contract and --

A We don't apply contracts.

Q I understand, and I don't -- I understand you don't. But I don't understand how you telling a provider and a carrier what would be due and owing under the MRA, how that is a determination as to whether the carrier properly adjusted or disallowed payment in the case at hand.

A We told them according to our applicable reimbursement schedule, and that is our schedule.

Q Okay. Would it surprise you to know that Mr. Sabolic agreed that the Agency does not make a written determination as to whether the carrier properly adjusted or disallowed payment in the circumstances that we are talking about right now?

A I have no idea what he said or didn't say.

Q No, I know you don't. I just asked you if it would surprise you.

A That he wants to apply a contract, which is what you are claiming --

Q No, can you read --

A -- that would surprise me, that he wants to apply the contract.

Q That's not what I said. Actually, I am going to have the court reporter read my question back.

(Whereupon, the court reporter read the requested portion of the record.)

THE WITNESS: So that you are applying that to a contract?

BY MS. HINSON:

Q Right, Mr. Sabolic testified that when a reimbursement contract is alleged, the determination that the Agency makes is not a determination as to whether the carrier properly adjusted or disallowed payment.

A That is correct, because we do not apply the contract.

Q Okay. Okay. When you make the determination under the MRA when a contract is alleged, do you know whether the carrier, then, is mandated by the 30-day requirement in (d) to make additional payment to the health care provider?

A I don't -- I don't handle that, but I don't

believe so.

Q Okay. And if you look down at (f), (f) is a provision that states that any carrier that engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments to health care providers may be subject to one of the penalties that are enumerated there. Do you know whether any carrier has ever been penalized under this section?

A Our section does not do that. That's Monitoring and Auditing.

Q So is that a no, you don't know?

A You would have to speak to Monitoring and Auditing. I have no idea.

Q I have -- I am just asking if you knew.

A I have no idea.

Q Okay. In your opinion, how does the proposed rule impact hospitals or other health care providers that file workers' comp reimbursement dispute determinations?

A Impact them in what way?

Q In any way.

MR. TERRY: Objection, foundation.

THE WITNESS: Since we've been doing it for about two years and nobody has objected, I guess there is not one, or we would have had an objection

way before now.

BY MS. HINSON:

Q Well, you know, you testified to that earlier, and plenty of objections have been made. That's actually why we are here today, because all of the petitioners in this matter have objected, so I just wanted to clarify that for you.

Do you think that the proposed rule has an impact on health care providers who come to the Division seeking reimbursement dispute resolution if a contract -- if a reimbursement contract is alleged?

A I don't know.

Q Okay. Do you know whether it affects or impacts workers' comp carriers?

A I don't know.

Q Who are the parties to a workers' comp reimbursement dispute that's submitted to the Agency?

A You have the provider and you have the carrier.

Q Okay. Do you know whether the Agency takes any action to determine whether a contract does, in fact, exist if one is alleged, by either the health care provider or the carrier?

A Currently, they submit portions of those contracts.

Q So when they file a reimbursement dispute and the contract is alleged, they currently also --

A The petitioner includes portions of the contract.

Q Okay. And what do you do with the portion of the contract that --

A We don't do anything with it now.

Q Okay. Do you know, over the course of the last two-and-a-half years, or I think that's about how long you have been -- not you -- the Agency has been implementing this policy; do you know approximately how many petitions have been filed and that do allege that there is a contract that applied?

A I don't know.

Q Okay. Are you able to state whether it's few, 50-50, many?

A I honestly don't know.

Q Okay. How many do you personally counter?

A Again, I couldn't tell you.

Q How many petitions do you review on a daily basis?

A Daily basis?

Q Yes, ma'am.

A It depends on the volume that's coming in and how involved they are. I have had one case take me an

entire week, so --

Q Then maybe a better question is on a monthly basis?

A On a monthly basis, probably around 150, I guess.

Q Okay. And of those 150, are you able to estimate about how many allege a reimbursement contract or a management care arrangement?

A No, because we aren't looking at them.

Q Oh, do they not come across your desk, then, if one has been alleged?

A They come across the desk, but if they have yes or no marked, it doesn't apply anymore, we go ahead and work the contract. If they have yes, we check off that it's a contract, and then we know when the determination comes out that the language will go in, but we still work it according to our rule.

Q I see what you are saying, okay.

Has the number of petitions that you personally have reviewed gone down at all? Have you noticed any difference in the number of them since the Agency implemented this policy?

A Due to the policy?

Q Yes, ma'am. Well, I mean, at all, I guess, but, yeah, if you can tell me due to the policy.

A I doubt due to the policy. We have had a decrease because of prescriptions not coming in in the volume that they were.

Q Okay. Are you familiar with how many determinations you make, or the Agency makes, ultimately get appealed to the Division of Administrative Hearings?

A I don't.

Q Okay. Do you know whether the Department gets a notice of those petitions that are referred to DOAH?

A I am sure they do, but you would need to speak to legal.

Q Have you ever had to testify in any DOAH hearing?

A Yes.

Q And when is the last time that you had to testify in a DOAH hearing regarding a reimbursement dispute?

A Maybe four or five years ago.

Q Okay.

A I am not positive on the timeframe.

Q And over the course of 11 years, approximately how many times would you say you have had to testify?

A I think it was three times; but again, it's been a while.

Q Okay. I am going to ask you a question

similar to the question Ms. Dailey asked you. I did note that you were listed as a potential trial witness. Is there any other testimony that you know of that you are going to give at the hearing?

A No, not that we haven't gone over.

Q Okay. Are you familiar with the nature of the testimony that you are going to give?

A No.

Q Okay. It's listed as giving testimony regarding the difficulties in applying reimbursement contracts. Does that sound consistent with what you are aware of?

A Probably, but I haven't been told directly that's what I am going to be doing.

Q That's fine.

If you will give me just one moment, I should be done.

MS. HINSON: Okay. I don't have anything else.

MS. DAILEY: I think we would like to make the same reservation that we've made in previous depositions, that we will remain open, this deposition will remain open or continued pending the outcome of discovery and the document production between the parties. And also,

Ms. Pumphrey, if there are areas identified of her testimony that we have not outlined and covered today --

MS. PUMPHREY: We will advise you.

MS. DAILEY: -- then we would ask to be advised.

Anything else?

MS. HINSON: I don't think so.

We would make the same reservation as Ms. Daily.

MS. DAILEY: Okay. I think we are finished. Thank you.

(Whereupon, the deposition was concluded at 2:50 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 15th day of September, 2017.

DEBRA R. KRICK
NOTARY PUBLIC
COMMISSION #GG015952
EXPIRES JULY 27, 2020

CERTIFICATE OF REPORTER

STATE OF FLORIDA)
COUNTY OF LEON)

I, DEBRA R. KRICK, Professional 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 4 through 68, 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 15th day of September, 2017.

Debbi R Krick

DEBRA R. KRICK
NOTARY PUBLIC
COMMISSION #GG015952
EXPIRES JULY 27, 2020

ERRATA SHEET

I have read the transcript of my deposition, Pages 4 through 68 and hereby subscribe to same, including any corrections and/or amendments listed below.

DATE: _____ _____
ARLENE COTTON

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

PAGE/LINE	CORRECTION/AMENDMENT	REASON FOR CHANGE

DATE OF DEPOSITION: AUGUST 29, 2017

REPORTER: DEBRA R. KRICK