In The Matter Of:

ZENITH INSURANCE COMPANY v
FLORIDA DEPARTMENT OF FINANCIAL SERVICES

LYNNE METZ
September 14, 2018

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Tallahassee, Florida

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STATE OF FLORIDA
DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION
MEDICAL SERVICES SECTION

ZENITH INSURANCE COMPANY,

Petitioner,

DOAH 18-3844
MSS Case No: 20160420-005

v.

FLORIDA DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF OF WORKERS' COMPENSATION, OFFICE OF MEDICAL SERVICES,

Respondent.
_____/

DEPOSITION OF:	LYNNE METZ
TAKEN AT THE INSTANCE OF:	THE PETITIONER
DATE:	September 14, 2018
TIME:	Commenced at 9:09 a.m. Concluded at 10:32 a.m.
LOCATION:	Florida Department of Financial Services 2012 Capital Circle, SE Tallahassee, FL 32301
REPORTED BY:	STEPHANIE JORDAN NARGIZ stephjordan@comcast.net Certified Court Reporter Florida Professional Reporter

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ALSO PRESENT:

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I N D E X

EXHIBITS

(Exhibits are attached)

The following deposition of LYNNE METZ was taken on oral examination, pursuant to notice, for purposes of discovery, and for use as evidence, and for other uses and purposes as may be permitted by the applicable and governing rules. Reading and signing is not waived.

* * *

THE COURT REPORTER: Will you raise your right hand, please. Do you swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

Thereupon,

LYNNE METZ

the witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. DOUGLAS:

Q. Good morning, Ms. Metz.

A. Good morning.

Q. As you know, we're here for your deposition in a workers' compensation reimbursement dispute. I won't go over everything I might normally ask. Some of the things are fairly obvious, but we really need to get into some details. You're under oath. I guess you know the drill, correct?

A. Correct.

Q. Could you state your full name, please?

A. Lynne, L-Y-N-N-E, Metz, M-E-T-Z.

Q. And where are you currently employed?

A. I'm employed by the Department of Financial Services in the Division of Workers' Compensation, Medical Services Section.

Q. And what is your job title here?

A. Registered nurse consultant.

Q. And briefly, kind of generally, what are the job categories or duties you take care of in that capacity as a registered nurse consultant?

A. I resolve reimbursement disputes between health care providers and carriers. I also work on the reimbursement manuals as far as writing for approval by the administration. I attend rule-making workshops and hearings. I attend the three-member panel meetings. I also work in what we call the Carrier Report of Health Care Provider Violations section, and screen and assist the administration in the forwarding and processing of those investigations, and any other duties assigned by my program administrator. I work with my other coworkers in reviewing and assisting with their cases.

Q. Okay. And briefly, your program administrator is whom?

A. Teresa Pugh, P-U-G-H.

Q. And that's in the Medical Services section?

A. Yes, sir.

Q. And that's one section within the bureau of the division of the department?

A. Yes. It is within the Bureau of Monitoring and Auditing, which is within the Division of Workers' Compensation.

Q. Do you have a copy of your CV by any chance?

A. I believe my attorney does.

Q. If we could just attach it at your convenience. I don't need to go through it at this point.

But briefly, if you could tell us, you're a registered nurse?

(Exhibit No. 1 was marked for identification.)

A. Yes, I am.

Q. And you worked in a hospital setting for some number of years?

A. Yes. Approximately 14 years. I started as a critical care ICU nurse, cardiology and surgical. I ultimately over a few years was promoted to a head nurse of the surgical ICU trauma unit, which was most of my work, taking care of critical care patients.

I at one point flew helicopters to pick up trauma patients and bring them to my unit.

I did work at one point for a cardiologist as his hospital nurse, this was prior to ARNPs, and made rounds and put in pacemakers. I was a certified pacemaker technician for Cordis Pacemakers; implanted permanent pacemakers and temporary pacemakers.

Then I took a leave when I made a transfer to a different city, and I worked for two plastic surgeons in a freestanding ambulatory surgical center. I worked in their preop area, their intraoperative area, and in their recovery room. I also worked in their central sterile supply prepping instruments, instrument trays, and ordering implants.

Q. So it's fair to say you got a lot of hands-on nursing care in the surgical setting?

A. Yes. I even have had two and a half years here in Tallahassee in a medical surgical unit as a clinical educator, which is one of my personal passions, med-surg and orthopedics prior to coming here to the division.

Q. Is it fair to say you're able to review medical records for content, substance, to determine what treatment was provided, whether at first pass it seems to be appropriate to the diagnosis?

A. Yes, sir. I had 10 years' experience of that at Medicaid under their Physicians Services program where I did that on a daily basis, and I've been doing that ever

since I've been here at the division.

Q. And in addition to your RN licensure, you have some other certifications; is that correct?

A. Yes. At the moment one of them is not current, but it could be made current. I have been a certified coder, as they call it, medical billing coder. I'm trying to think of the first year. Let's see, I came here in 2007. That would be approximately 2005 or '04. I cannot remember the exact year. You can look at my CV. It is a clinical coding expert for physicians and hospitals, and ASCs through the American Academy of Clinical Coding. I still am a member of that, and I stay on their web site and their blog, and I stay up to date with current coding techniques at all times.

I was also a HIPAA implementation team member when the HIPAA guidelines came in. And I stay up to date all the time on current trends.

Q. Okay. Is it fair to say the certified -- you said medical coder or professional coder?

A. Professional.

Q. Okay. So the CPC --

A. CPC is my title.

Q. And that's something you use in your current job as a nurse-auditor -- or consultant, excuse me?

A. Yes.

Q. And that allows you to audit medical billings?

A. Yes. Review.

Q. Review.

A. Review for proper coding, documentation, and billing.

Q. Is that part of the medical bill review process in your current job?

A. Yes.

Q. Do you have any other certifications or licensures or education that are relevant to your current job, in particular to the current case we have?

A. Not particularly.

Q. Okay. And so that we're clear and we don't make a mistake, we're here on a case involving a patient by the name of -- and please don't type his name -- if you don't mind leaving that out. (Redacted name) Does that sound correct to you?

A. I'd like to check to be accurate. I'd prefer to take my case file.

Q. Sure.

A. As you can see, it's rather large.

That is correct.

Q. And what is the Medical Services section case number you have on that?

A. It would be -- these are caps, MSS case number

20160420-005.

Q. And the provider whose bills are at issue are Lawnwood Regional Medical Center?

A. Lawnwood, yes, Regional Medical Center.

Q. What dates of service do you have on that?

A. From the medical bill, the statement period is January 21st, 2016 through January 25th, 2016.

Q. For clarity, do you have the amended determination in front of you, the one that is at issue today?

A. Yes, sir.

Q. And I think you indicated the medical documentation confirmed the first date of service was January 21; is that correct?

A. The medical bill says at the top, "statement covers." So let me look at the bottom. I apologize. Principal procedure. The first procedure was performed on January the 20th.

Q. Okay.

A. But their statement in this bill is at the top, January 21st. So all of this is covering as of my amended statement -- or amended determination shows January 20th through January 25th.

Q. So the clarification is --

A. So they must have done some type of procedure on

the 20th. And then this end patient bill began the 21st, which is proper billing.

Q. Okay. So the determination will say 1-20 through 1-25, but the billing at issue is 1-21 through 1-25 for four days length of stay?

A. Four days length of stay. And let me explain that answer.

Q. Okay.

A. They may do a procedure or laboratory work, any type of, I'd say, outpatient service. All services prior to an inpatient admission are what we designate as rolled in to the inpatient admission. So although the service date may be a day before, they have to just roll them up, all charges go into --

Q. Okay.

A. -- an inpatient administration. So although the statement date may be the inpatient only days, because they weren't admitted until the certain date as a status of inpatient, there were outpatient services done before those days.

Q. Okay.

A. So there may be a day before, but the inpatient overnight stays are less.

Q. Okay.

A. Does that make sense?

Q. It does. And so the record is clear, then, we're talking a four-day length of stay?

A. Correct. With all charges included on that bill.

Q. Okay. And you obviously got something to review, is that correct, at some point in time where the provider petitioned for resolution of reimbursement dispute?

A. Yes, sir.

Q. Okay. And you got medical documentation to review, I presume?

A. Yes, sir.

Q. Do you know what type of injury this was?

A. This was a post-injury -- post-work-related injury from -- I believe it was a fractured hand, and the injured employee was coming in for a surgical procedure to release some scar tissue in an index finger, because the finger was either not movable or it was in an awkward position, or it wasn't as usable.

Q. Okay. So as indicated on your amended determination, his accident date was actually four months earlier on September 20th of the previous year 2015?

A. That's correct.

Q. So we roll over to January, four months later, they're doing a surgery on his index finger. Is that a fair, general description?

A. That's correct.

Q. You reviewed the medical documentation to confirm all of this when you got it; is that correct?

A. Yes.

Q. And there isn't any dispute about the procedure that you saw; is that correct? For example, Zenith isn't saying they didn't need it or anything like that, the bill is really just about the high -- what is viewed as an unreasonable charge for the index finger surgery. Does that characterize the issues reasonably from your perspective?

MS. HARNAGE: I'm going to object just to that compound question and her thoughts on whether or not the charge is reasonable.

MR. DOUGLAS: I'll get to what she thinks about reasonable.

Q. But what is the disputed issue in the amended determination that you issued? And I'm jumping ahead, of course, but you issued the amended determination in this case; is that correct?

A. That is correct.

Q. What was the date of the amended determination?

A. The amended was signed and dated by me on June 14, 2018.

Q. And the fact that there's an amended determination presumes that there was an earlier

determination; is that correct?

A. That's correct.

Q. When was the initial determination issued?

A. I would have to take a look.

Q. Okay.

A. And I apologize. Let me see, it's the -- I just saw it, I believe. I apologize, I do not have it.

Q. That's okay. Is it fair to say it was months, if -- well, the surgery date here is January of 2016; is that correct?

A. That is correct.

Q. And the amended determination is June of 2018?

A. That is correct.

Q. And I just got a copy of the interrogatory answer suggesting that the amended determination was issued because of Judge McArthur's order on the rule challenge from late November, early December 2018. In other words, you issued an amended determination because there was an order from an ALJ about something; is that correct so far?

A. Yes.

Q. Okay. So the initial determination was issued sometime before November of 2018; is that a fair assumption?

A. I don't know if that date is correct.

Q. '17, I'm sorry.

A. '17, I believe, but, yes.

Q. Okay. Do you know off the top of your head how the initial determination compared or differed with the amended determination?

A. Yes.

Q. What did the initial determination say in comparison to the amended determination?

A. The initial determination was calculated pursuant to the statute and our rule, and reimbursed per the stop loss after implant carve-out methodology.

Q. I'll get to that -- what that is in a second.

A. And the amended determination reimbursed using the same methodology and applied the petitioner's submitted contract discount of 5 percent for the first health contract.

Q. Did the initial determination include an order to pay based on the stop loss -- you didn't have a per diem, based on the stop loss methodology you talked about?

A. Yes.

Q. Did it say anything about the contract, whether the parties were to pay or resolve according to the contract, if you recall?

A. There is language which is a text language in the determination that says that the department will not address the contract language, that we will address that

these calculated figures are for the maximum reimbursement allowances per the statute and the rule, which is our fee schedule amount. If there is a contract involved in this dispute, that is between the parties.

Q. Okay.

A. Shall be reimbursed the contract amount between the parties.

Q. So you calculated using a certain methodology, and then there was this language at the end to say apply the contract yourselves?

A. It's up above the fee schedule table, but yes, it's in there.

Q. Okay. And then it sounds like in the amended determination you went ahead and applied a 5 percent network discount according to some formula that was given by either the provider or the carrier, or somebody, as the contract rate?

A. It was provided by the petitioner, and it is calculated to determine the correct total reimbursement.

Q. And I'll have to come back either today or at some point to ask about MRAs and fee schedule and what all of those mean.

A. Okay.

Q. Is that something you're familiar with?

A. Very much so.

Q. And it sounds like in terms of helping formulate rules, you've been involved in the process of writing manuals?

A. Yes, sir.

Q. Okay. So you're familiar with the manuals and what they call for; is that correct?

A. Yes.

Q. Getting back to the amended determination and the contract, before issuing one or both determinations, you obviously reviewed the medical documentation; is that correct?

A. Yes.

Q. And you reviewed the bill --

A. Yes.

Q. -- is that correct?

And you would have reviewed an explanation of benefits or explanation of bill review from the carrier?

A. Yes.

Q. And all of those are mandatory parts of the process; is that correct?

A. Yes.

Q. And I think we used terms EOB or EOBR?

A. EOBR is our term to use. The division's specifically identified acronym, EOBR, explanation of bill review.

Q. So there's a rule process for carriers to complete EOBRs?

A. Yes.

Q. In between issuing the initial determination and the amended determination, did you review anything besides the 5 percent discount language from the contract provided by the hospital?

A. I did not.

Q. So the first determination was calculation of a methodology, a formula, and the language about pay according to your contract. And the second one was where you're applying the 5 percent discount from the initial methodology?

A. Between the initial determination and the amended, that is exactly what I addressed, was the contract only.

Q. Okay. Did you review any other parts of the contract before issuing the amended determination?

A. Yes.

Q. What other parts of the contract did you review?

A. The date that it was signed by the parties, to make sure that it fell within the proper date of the dates of service, to make sure that the petitioner was included on that contract, that a member or a representative of the petitioner had physically signed it, to make sure the

petitioner's name was on there as one of their several hospitals listed; to make sure I could find Lawnwood Regional's name on there as one of the participating facilities; and I read the specific paragraph that identified a 5 percent discount from the allowable fee schedule.

Q. So it sounds like you confirmed that the contract applied to the dispute?

A. Yes.

Q. And you have a rule now in place about confirming that; is that correct?

A. As well as the petition form has a question number 5, and I made sure that the answer to that was yes and that the carrier response agreed with that question.

Q. Okay. So it's not disputed by anybody that a contract, a reimbursement, some sort of contract applies?

A. That contract applied.

Q. In your capacity as an RN consultant in reviewing bills, issuing determinations, and also participating in workshops and rule development, have you been made aware that there's multiple parts to these contracts for reimbursement?

A. After reviewing a lot of different contracts through my years, I am aware that there can be.

Q. And it sounds like your review of the contract

was limited to confirming that the contract applied to the dispute and the parties and the date at issue, and then the percent discount method of reimbursement in the contract; is that right -- or rate?

A. I've reviewed all of the pages of the contract and what applied and what did not apply.

Q. Does the division have a copy of the contract that you had in place at the time to review?

A. I have it right here.

Q. This is marked Exhibit F. Do you know how it -- and who marked it as Exhibit F?

A. It came in from the petitioner as attachments to their dispute form marked Exhibit F, and then identified in a list as their contract Exhibit F.

Q. Okay. So the provider --

A. On the petition form.

Q. In the first pages of Exhibit F provided by the hospital is an amendment, it's called Amendment to Model Facility Agreement, and that's basically a two-page document plus exhibit to the document.

A. Looks like more than two pages there.

Q. I'm just going to move these apart. So looks like pages 1 and 2 is the Amendment to Model Facility Agreement.

A. Yes.

Q. And I may have gotten these out of order. So this would be -- there's a 5 and 6 here, and then an unnumbered page there. So something's out of order.

A. This comes in on the top somewhere or in the middle. So this is 1, 2, 3.

Q. Okay. So it's --

A. Actually, it comes in this way. I apologize. This is how it comes in to us. I've seen this numerous times, so I'm very familiar with this. It comes in this way and then you have this, and then you have -- that's right.

Q. Okay. And it looks like --

A. This is the order we've seen this document on numerous.

Q. Okay. So you didn't have any question about this being something that applied to the provider?

A. Not at all.

MR. DOUGLAS: Thank you. We'll go ahead and attach a copy of that, please.

(Exhibit No. 2 was marked for identification.)

Q. Are you aware there's a separate agreement that ties the carriers to the Coventry -- the Coventry to the First Health Network and then to the hospitals?

MS. HARNAGE: I'm going to object to speculation.

Q. (By Mr. Douglas) Are you able to -- is that

something you're aware of?

A. I did not see one.

Q. Okay. Have you in the process of working for the division as a nurse RN consultant been made aware that there's multiple parts and more pages to these contracts than what you saw in the provider petition documents?

MS. HARNAGE: I'm going to object to speculation of that.

A. When I work a reimbursement dispute, I only work the evidence that is provided per case.

Q. Will it be surprising to you if you hear at final hearing that there are other documents and provisions involved other than the rate sheets that you're looking at?

MS. HARNAGE: Object to speculation and any of her personal feelings about that.

MR. DOUGLAS: I'm just asking what she knows apart from actually looking at just that one document.

Q. Is that something you can answer?

A. I don't know how I would react.

Q. Okay. Getting back to my kind of train of questions on the contract. So you looked at this agreement, you applied the rate, and that was the contract as far as you were concerned; is that fair?

A. It is the contract that the petitioner submitted

in asking for a discount for their reimbursement.

Q. Did you look at any law or get any legal opinions about what principles of law would apply to interpreting the contract once you got the carrier response?

A. No.

Q. You received a carrier response to provider petition; is that correct?

A. Yes.

Q. Do you recall offhand what that said, or do you need to take a look at it? I assume you do.

A. It was pretty simple. At least on the form. Let's address the carrier response form.

Q. The form. Okay. So we're going to talk from your memory, then, about what's on the form?

A. On the form it says, "See attached pages" very clearly. And then it says that Zenith Insurance Company does not have a direct contract with provider. This is the summation.

Q. Okay.

A. It says basically we have a contract with Coventry, who establishes network contracts with network providers. So it is not their direct contract with the provider. This contract will -- and generally, what they say is this contract will be submitted under separate cover. I don't know if the carrier response in this one

said that. Carrier response is green -- pardon me. I have it right here, exactly, that they say that -- give me just a moment, Mr. Douglas. I have it labeled.

Q. Okay.

A. Zenith has network contract. They agree, first of all. And this is in response to question number 4: Does the carrier agree or disagree with the petitioner's response to question number 5 of the petition for resolution of reimbursement dispute? Zenith has network contract between Zenith and its network vendor, and this network vendor maintains direct reimbursement agreements for providers actually providing services in Florida. That's all it says.

Q. Okay. And I think you said you recall in some of the carrier responses you see Zenith indicating they will provide that contract under separate cover directly from Coventry?

A. Coventry, historically.

Q. Okay. So you're aware there's this other Coventry agreement out there somewhere?

A. There's something out there on this case, I believe. There should have been.

Q. Okay. So that was the form response from Zenith; is that correct?

A. That is correct.

Q. And that form is required by department rule; is that correct?

A. If the carrier elects to respond, it must be on the form.

Q. Is there anything in the rules that prevents the carrier from using a continuation of response and typing out or submitting additional written information?

A. No. They may use all the pages they need.

Q. And in this case, did Zenith issue additional pages in the form of a continuation of response?

A. Yes, they did.

Q. And did you review all of the pages of that?

A. Yes, I did.

Q. How many pages are just in the continuation of response?

A. I did not count them, but there were many. A large volume.

Q. In addition to the written continuation of response -- and I have nine pages. Does that sound about right?

A. Approximately.

Q. Did they also submit any exhibits or documentation?

A. They may have.

Q. Do you recall the Medi-Span comparison to some of

the charges submitted as -- attached as exhibits?

A. Yes.

Q. Do you recall the Healthcare Bluebook comparison?

A. That may have been in there. I do remember typed numbers.

Q. Okay. And then Optum 360 EncoderPro describing what the CMS reimbursement would have been for these procedures or this inpatient stay?

A. I do remember that being typed in. I do not remember necessarily the actually page.

Q. Okay. And in going through the document patient submitted by the hospital with its petition and its bills, do you recall seeing anything in the hospital's documentation that included a coding sheet?

A. There was an itemized statement.

Q. That's -- the itemized statement is the itemized list of all the services provided; is that right?

A. Yes.

Q. Do you recall any other sheets that would have described what Medicare would have reimbursed for this DRG code, this inpatient stay?

A. I do not recall seeing that and I did not look for that.

Q. Okay. Do you recall whether Zenith raised that in their response or continuation of response to provider

petition?

A. Yes, they did.

Q. What do you recall from that?

A. I recall that there were multiple statements regarding a comparison between the billed charges to the carrier, Zenith, and the reimbursement that Medicare would have paid and a comparison as to that percentage. However, comparing what the billed charges are versus the reimbursement is not an adequate or proper standard, because you have to compare billed charges to billed charges. Comparing billed charges to reimbursement is different, because there's different payment methodologies. The division does not pay in the same method that Medicare pays. Medicare has a different reimbursement formula. So it did not address how did Lawnwood Regional Medical Center bill Medicare.

Q. What doesn't address it, your --

A. The carrier's response.

Q. Do you know what Medicare regulations require in terms of how a provider -- hospital bills Medicare for inpatient?

A. Yes.

Q. What do they require?

A. I used to work with Medicare payments over at AHCA.

Q. Okay.

A. Hospitals are required to have something that is called a chargemaster. A chargemaster is simply an inventory list of every supply, item, surgery by procedure code, everything, and the hospital's actual charge regardless of who's paying for it, including indigent care, self-pay, no pay, everything. It must be on file with the federal government, meaning the centers for Medicaid, Medicare services. They have to have this on file at a minimum annually. They're only allowed to alter that chargemaster once a year when they can show a significant change in their costs, meaning retail purchase price of supplies. And this is done for the calculation of the congressional Medicare budget. So they -- if they are billing by their chargemaster, which is a requirement for federal Medicare payments, they must bill all payors the same way. So the bill to the division should be the same bill that they charge to Medicare. So charges to the carrier, Zenith, should be the same charges that they billed Medicare -- or they billed Aetna or they billed Blue Cross Blue Shield. Charges are identical. It's how something is reimbursed that is different. And that's by policies or law. Medicare is under law of congress. The division is under law of statute and rule. I can't speak to Aetna and some of those people.

Q. Okay.

A. So comparison of payment is how reimbursement is to reimbursement, charges to charges. You can't compare charges to reimbursement.

Q. Okay. So you're saying essentially charges are different than what's being reimbursed?

A. Totally.

Q. And Medicare has all of the data of what hospitals charge for various procedures?

A. Yes.

Q. And is there a Medicare database you can go to to verify what they reimburse for those charges?

A. I don't know.

Q. The charges in this case for a four-day length of stay were $163,697.30. Does that sound right?

A. Approximately, yes. I believe. 163,697.30.

Q. Okay. And the amended determination found that Zenith had already paid $31,844.08?

A. Correct.

Q. And they ordered an additional payment of $84,312.97?

A. That's correct.

Q. And if my math is correct, the total reimbursement for the finger surgery would be $116,157.67?

MR. NEMECEK: Form. I just don't know if this

medical records include treatment beyond just surgery on the finger. I'll defer to Lynne on that, but...

A. I'm not certain what your math --

Q. What's the total ordered reimbursement that the amended determination orders, the total final combined dollar amount to be paid to the hospital?

A. On the amended determination, the additional reimbursement amount due is $84,312.97.

Q. Okay. And I think it even shows a total correct reimbursement amount using the rule methodology, is that correct, on the second page of the amended determination?

A. It shows the total correct reimbursement amount would be $116,157.67.

Q. Does the work comp statute 440.13(12) in any section reference Medicare as a basis for reimbursement or payment to hospitals under workers' compensation?

A. No. For hospitals, no.

Q. You don't recall for any type of surgeries at all or any type of procedures, as statute --

A. For hospitals, the reimbursement amount, I do not believe.

Q. Under 440.13(12)(b)(5), it doesn't say hospitals specifically. But it says: Maximum reimbursement for surgical procedure shall be increased to 140 percent of reimbursement allowed by Medicare for the levels developed

and reviewed by the panel. Do you recall that?

A. That is for physician procedures.

Q. When you say that's for physician procedures, is that in the statute or is that in a rule interpreting the statute?

A. That is in statute.

Q. Does it --

A. And then it's also promulgated in the fee schedule, which is in the rule.

Q. And I'll get back to this in a second, but I kind of want to finish up on the Medicare piece. Do you know why or have any opinion since you did some of these reviews for Medicaid, which is somewhat similar to Medicare and -- is that fair?

A. Not similar, but go ahead.

Q. You're familiar with reviewing the Medicare -- you talked about Medicare?

A. Yes.

Q. Medicare must be billed the same charges as Medicaid, as workers' compensation?

A. That is correct.

Q. As Blue Cross, as United Health. Anybody else? If they get the same 163,000-plus dollars billed, do you know why they pay less than $9,000 dollars, according to the provider documentation?

A. Yes, I do.

Q. Why is that?

A. Medicare's reimbursement method is based on something that is an acronym called DRGs. Diagnosis-related groups. They look at the primary diagnosis for that particular patient -- let's call it a patient -- and then they look at any additional diagnosis, but the primary diagnosis, they are given a flat case rate, and X number of dollars for that diagnosis. And unless the physician, attending physician can add on additional diagnoses, like complications for that diagnosis, which would add on extra case dollars. So it's an all-encompassing case rate, regardless of the number of days in, seven days, two days, it does not matter. It includes every service, drug, dressing, everything. The facility costs are wrapped in.

Now, if there's a secondary diagnosis, a complication such as -- I'll give you an example: Infection. Then that infection earns another case rate. Fever, that one earns another case rate. But it's been in practice, I believe, since the '90s, 1990s, diagnosis-related groups, and Medicare pays that way. They do not pay on percentage of charges.

Q. And you mention the word "costs," and how the hospital can raise their chargemaster more than once a

year if they give some indication of increased costs to Medicare?

A. Actual costs.

Q. Actual costs.

A. And it has to be submitted to the centers for Medicare and Medicaid services, that is federal, and have it approved.

Q. But at the basis, then, these DRG reimbursements under Medicare are tied to Medicare's analysis of costs?

A. Nationally.

Q. Okay.

A. And it is passed in the congressional budget at congress annually. And it is taken off of national data based on only Medicare beneficiaries and their admissions to hospitals.

Q. Getting back to what you looked at, then. You did not necessarily see the Medicare rate in the hospital provider documentation, but it sounds like you saw that issue raised by Zenith?

A. Oh, absolutely. And it didn't relate to our statutory reimbursement amount.

Q. Sounds like you're stuck with a reimbursement methodology and you can't look at anything beyond the methodology.

MS. HARNAGE: Object to that.

MR. NEMECEK: Object to form.

A. Yeah.

MR. NEMECEK: Stuck.

Q. (By Mr. Douglas) So you're limited to that methodology in your particular review?

A. I am mandated.

Q. Okay.

A. To follow the statutes and the rules related to reimbursement of health care provider fees.

Q. I promise I'll briefly -- well, let me ask, what is the methodology employed in this situation, which is inpatient hospital surgery?

A. The name, as we would like to call it in the rule, is called reimbursement of total charges after implant carve-out, because this had a line item for surgical implants for an inpatient hospital claim. The first step is you subtract the billed charge for the implant, which I did.

Q. And this case, the implant was a minor thing.

A. It didn't impact the reimbursement dispute. So let's just forget that.

Q. So not a hip with an artificial joint?

A. No. It was $699, but you do have to subtract it. And then that subtotal, you look at whether it exceeds the stop loss threshold. In this case, it definitely did. It

was greater than the $59,834 or 43 -- I look at it as 59,8, and then I double check it. It did. And our rule, 69L7-5.10 says: The reimbursement must be 75 percent of that subtotal. So all of that gets 75 percent of the health care provider's or hospital's billed charge. Then, in addition to that amount, they get the allowed amount for the surgical. In this case the health care provider hospital was not asking for any money for the implants. So it didn't change the dollar amount.

Q. So the rule and statute as its dictated to you is basically 75 percent of this formula, this charge?

A. Yes.

Q. The hospital's charge. And that's pretty much the end of the story unless you have the 5 percent discount under the contract?

A. And then I applied the discount, that's right.

Q. And by rule, you're limited or in other words prevented from looking at anything else to issue proper appropriate reimbursement determination?

MS. HARNAGE: Objection to the "proper appropriate."

A. I'm not prohibited from looking at medical records to see that services were actually performed. I'm not prohibited from looking specifically to see, okay, the surgical implants, they're requesting this, did they

actually put them in?

Q. Right.

A. I'm looking for --

Q. The services were provided.

A. -- substantiated services. I look at the EOBR to make sure did the carrier disallow any specific items, what was the EOBR code, and was the carrier upheld or did the petitioner uphold? I have to look at everything.

Q. Okay.

A. But not in this case, because the carrier did not disallow for any reason of not sufficient documentation. They did not lack of medical necessity, anything.

Q. Okay. You can't look at what is a reasonable charge or a reasonable reimbursement under the rules?

A. We have no authority by statute to look at that.

Q. And that's, in essence, the crux of the dispute; is that fair to say?

A. Yes, it is.

Q. However, this was a contracted reimbursement according to the provider in Zenith; is that right?

A. It was the petitioner's contract, and they were requesting a discount of reimbursement.

Q. Are you aware that the contract allows the carrier to reprice, edit, and audit the charges?

A. The carrier may audit the chargemaster on any

health care provider. They may audit the chargemaster.

Q. May they also audit the bills -- I mean, is there a process for auditing bills in the statute or in the rule?

A. Yes. For billing errors and for over-utilization, they may.

Q. What is a billing error?

A. A billing error from a health care provider is that the health care provider did not follow the billing instructions as promulgated in our rule 69L-7, or they billed the incorrect CPT codes, they billed codes that they did not provide services, incomplete form completion. And it has to be a pattern, it can't be just one time. It's a pattern or practice of this type of behavior.

Q. And the statute also gives the division the authority to audit the provider's bills, is that correct, for billing errors among other things?

A. Yes. But it's to investigate. It does not say audit. The provisions say investigate.

Q. Okay. So it sounds like you wouldn't consider -- the division wouldn't consider the billing error if the provider just said, okay, we're going to double our charges this year?

A. We have no authority under the statute or the rule.

Q. And you can't do anything about that other than order 75 percent of whatever the new charge is?

A. That is correct. We have no authority under statute or rule.

Q. What if they double the charge for the same group of services every two and a half to three years?

A. We have no authority under statute or rule.

Q. Would it surprise you that it appears to be that's what's going on with some outlier charge providers?

A. Health care costs are increasing all over the country.

Q. Do you have any understanding of what the average increase for hospital charges is around the country or in Florida?

MS. HARNAGE: Object to -- when I object, just stop.

A. Okay.

MS. HARNAGE: And object to speculation for that.

A. I don't know.

Q. Do you have a personal impression, reviewing all of the bills you review, whether hospital charges are or should be increasing by 100 percent every two and a half to three years?

MS. HARNAGE: Same objection.

A. My personal opinions don't fall into my work

requirements.

Q. Right.

A. My work requirements are to follow the statute and the rule. I have to follow what I'm given when I work a reimbursement dispute.

Q. So you're not really supposed to answer that in your official capacity; is that right?

A. Reword that, please.

Q. Let me ask you this way: How many bills, as an RN consultant, do you review in a month or in a year?

A. I can quote last year's fiscal year.

Q. Okay.

A. Statistic. I reviewed over 500 disputes. I reviewed nine cases of carrier-reported health care provider violations that could be billing errors or whatever, and that doesn't count consults with other nurses, just to review some bills.

Q. How many of the disputes involved hospitals that you personally reviewed?

A. I don't know the percentage.

Q. Do you have a rough estimate?

A. I can't separate the inpatient from the outpatient.

Q. And regardless of whether it's inpatient or outpatient, they'll submit an itemized bill with a total

charge; is that correct?

A. 60 percent.

Q. In your capacity where you participate in rule making and review the setting or recommendations for MRAs, do you review hospital charges?

A. Yes.

Q. Do you have some sense from the two types of parts of your job, reviewing disputes, 60 percent of which are roughly hospital and setting MRAs, what it costs or what is a common charge or range of charges for hospitals for a four-day length of stay following something like a hand or finger surgery?

A. I do not review inpatient hospital charges regarding setting MRAs. MRAs are already established through the statute and the rule for inpatient hospital.

Q. That's because you have the daily per diem type reimbursement for inpatient?

A. Either the per diem or the stop loss methodology.

Q. Or the stop loss. And the stop loss is the 59,8, I think you said?

A. Approximately.

Q. $59,800 and change.

A. Yes, and change. Thank you.

Q. And if they manage to charge more than that, they just get the straight percentage of the total charge?

A. Obviously, we may have the carve-out of the implants with that, but it must exceed the 59,8 after you subtract any implants.

Q. And what is the per diem as of January 2016? Was it 3,900 and change or so per day?

A. Approximately.

Q. So a little less than 4,000 a day to round up?

A. To round.

Q. But if you bill more than -- we'll round up $60,000, not counting implants, you go from 4,000 a day to 75 percent of whatever you charge?

A. That's correct.

Q. And having taken care of that little housekeeping thing in the rule about how the reimbursement works, you looked at 60 percent of 500 disputes would be about 300 hospital disputes a year. And how long have you worked for the department?

A. Almost 11 years, say 10 and a half.

Q. You've reviewed thousands of hospital bills?

A. Yes.

Q. Give or take 3,000?

A. Yes.

Q. Do you think from your experience -- or do you have any impression whether $164,000 is a lot of money for a finger surgery?

MS. HARNAGE: Objection. Form. Personal opinion.

MR. NEMECEK: Lynne, he's just asking impression, not opinion. Okay.

A. Impression, okay. It is a large bill. I have to look at the actual items that were billed, and in this case there were a lot of drugs --

Q. Okay.

A. -- billed, which are highly expensive medications. And there was vascular surgery performed.

Q. Okay.

A. It wasn't, in my opinion as a clinical nurse, a minor surgical procedure, but it is a high bill.

MR. NEMECEK: I'm going to move to strike opinion. He's just asking about impression, Lynne.

A. Thank you.

Q. Are you aware this was originally scheduled as an outpatient -- minor outpatient surgery?

A. Yes.

Q. And the billing itself in the coding references minor surgery?

A. Scheduled for that.

Q. But they nicked an artery or a vein or something like that when they were messing with the index finger tendon; is that right?

A. That is correct.

Q. And that's what led to the inpatient and the four days of length of stay?

A. That's correct.

Q. But it was still a finger. And if I understand correctly, your impression was it's a high bill even for that?

A. That's correct.

Q. I'm going to come back to how -- let me just ask: The stop loss, that's just under $60,000. How was that calculated by the department or the three-member panel?

A. I believe that's better answered by Mr. Sabolic.

Q. Did you participate or review any documentation to suggest that's a good number for the stop loss?

A. I have read it, but I cannot answer whether it's a good number or not. That's Mr. Sabolic's area.

Q. So he'll know what that reflects or why that number was chosen?

A. That's correct.

Q. Do you have a sense of whether most hospital bills fall, are less than $60,000 even for a four-day length of stay?

A. I believe Mr. Sabolic should answer all of that. I was only involved in the answers to some of that one time. Most of those meetings are between NCCI and

Mr. Sabolic. And I don't always attend those meetings.

Q. Okay. Jumping back to -- you mentioned that there were a lot of medications used?

A. Yes.

Q. And you didn't necessarily look at what those were. You mentioned you'd have to look at them to know if the bill was high because of the medication, for example?

A. Yes.

Q. What is Medi-Span, Medi-Span drug database?

A. Medi-Span drug master database is a pricing database that the division uses to find the average wholesale price of dispensed medications that are given to patients in physicians' offices.

Q. And the division recognizes Medi-Span by rule and by statute as a valid basis for comparison of average wholesale price?

A. For physician-dispensed medications, yes.

Q. But in terms of the accuracy of the database, you accept it as accurate?

A. By statute we are mandated to.

Q. And I won't go into -- do you have an understanding of what AWP or average wholesale price, as that term is technically used, what it means or what it represents?

A. Yes. It is defined in the statute.

Q. Do you know or have any understanding of how the system works where there's this initial AWP affixed to a drug, but then there's discounts and coupons and refunds, and so that the final price is actually less than the AWP in the vast majority of cases?

A. I'm very aware of drug rebates and discounts.

Q. Do you have an impression whether what's in the -- what's listed as an AWP in Medi-Span actually costs less at the retail end than it does at the average wholesale price end?

A. I cannot answer that full chain and the outcome, because I'm not involved in that industry.

Q. I'll ask you this way: Do you have an impression whether you can go to the pharmacy and buy a drug without insurance for less than the AWP?

A. Yes.

Q. Okay. So is that fairly common?

A. I don't know how common it is.

Q. Okay. Did you look at Zenith's list of drugs and how they compared with the Medi-Span database for AWP?

A. Yes.

Q. And I think you already indicated you can't do anything about that, you're stuck with the 75 percent of charges; is that correct?

A. That is correct.

Q. But looking at the comparison, do you have an impression whether there was a large markup above AWP for the drugs submitted for reimbursement by the hospital?

MS. HARNAGE: Objection about the speculation of markup.

A. The hospital charged their charge from the chargemaster as listed on the itemized statement and the bill. I can't tell you how they receive or calculate that itemized statement which is reflected on the bill. However, it is different. It is higher.

Pardon me, Mr. Douglas. I'm going to get a mint for my mouth.

Q. Sure.

A. Thank you.

Okay. I'm ready.

Q. Along the lines of what we were talking about, did you see where the hospital was charging $111 for one basic oxycodone 5 milligram tablet, the 53.25 combination?

A. On the itemized statement?

Q. Yes, ma'am. And as also described in Zenith's carrier response.

A. Oxycodone APAP 5?

Q. Yes, ma'am.

A. $111.

Q. Does that strike you as a little high given all

of the bills you reviewed before, and just your general experience?

A. It is higher than I have seen.

Q. And if Medi-Span drug database shows that the AWP for that drug is 35 cents?

A. Yes.

Q. Does that seem consistent with your experience?

A. It depends on the manufacturer, where they purchased it, but it can be that amount.

Q. Okay. And they're supposed to list the price according to the National Drug Code, and so if the Medi-Span comparison is to that actual pill going back to the original manufacturer; is that right?

A. That is not correct.

Q. It's not?

A. That is for dispensed medication in a physician's office. The Medi-Span master drug database is for dispensed medications. These are not dispensed for a patient to take home.

Q. You're saying the rule adopted by the division is to apply Medi-Span only for dispensed medications?

A. The statute.

Q. Okay. The rule in the statute?

A. And statute.

Q. The Medi-Span has a comprehensive charge of all

drugs and the arrearage and all AWP assigned to that drug?

A. Correct. But the statute is not reflected for inpatient hospitals or outpatients.

Q. So the conclusion is you can't do anything about it because you're stuck with 75 percent of whatever they want to charge?

A. Correct.

Q. Even if when it comes to the 35 cent pill, they want to charge $111?

A. That is correct.

Q. So 31,000 percent markup is just what we're stuck with according to the rule and the 75 percent reimbursement methodology?

A. That is correct. There's no formula for the charging of drugs or medications in hospitals.

Q. And does the same apply to bandages?

A. That is correct.

Q. Okay. So, for example, did you see in there where they charged $54 for a four by four gauze pad?

A. Yes.

Q. And you're aware you can go to Walgreens or Walmart and buy 24 of those things for less than $5?

A. I don't know the exact price, but I know --

Q. Does that seem ballpark consistent?

A. Approximately, yes.

Q. So they're about 20 cents each?
A. Yes.
Q. About a 200 -- it's marked up about 257 times from what us people who don't buy in bulk can go get?
A. Don't know that's the math, but it's close.
Q. We're stuck because of the methodology?
A. Yes, sir.
Q. Now backing up to the rule, that stop loss, it's just under $60,000. They only get a little less than $4,000 per day if they charge less than $60,000?
A. Yes.
Q. What's to stop them from saying, okay, we used to charge 40,000, we're going to double it to beat the stop loss?
MR. NEMECEK: Speculation. You can answer if you know.
Q. (By Mr. Douglas) Is there anything in the rules or the statute or the interpretation that's given to you that stops them from doubling their charges just to beat the stop loss?
A. The only control on charges is the chargemaster federal rules.
Q. As long as they double it in their chargemaster, they can --
A. And if the center for Medicare and Medicaid

services will annually approve their chargemaster, it is their chargemaster.

Q. There's a disconnect, and I'm lost, and I don't want to spend too much time on it. Why would Medicare approve Lawnwood Regional Medical Center chargemaster for $164,000 if they say we don't care, you still get $9,000 for the whole deal? Is there a disconnect?

A. Okay.

Q. Does that really protect consumers or payors who are stuck with a methodology based on a percent of charges?

A. For Medicare -- that's the only reason the federal government looks at the chargemaster is for Medicare purposes. They're not looking at that submission of the chargemaster for any other reason. They're not looking at it for private insurers, self-pay, workers' comp, any other PIP. It does not matter.

Q. Okay. Have you reviewed any documentation or database such as the FAIR Health database for information subsequently provided by Zenith about what payors -- or excuse me, what hospitals, providers in Lawnwood's region charge for the same procedures?

A. Are you asking following the issuance of my amended --

Q. Yes, ma'am.

A. -- or original?

Q. Yes, ma'am.

A. No, I have not.

Q. How about before that, have you seen any data of any kind, even the division's own data of what providers charge for the same services?

A. No, I do not. That is not a process for our issuance of reimbursement dispute determination. We look at the evidence that is provided, and we follow statute and rule.

Q. How about just in your rule development, have you looked at any provider charges to find out what other providers in Lawnwood's region charge for the same or similar services?

A. No. And if it has any approach to that, Mr. Sabolic would be able to answer that.

Q. I'll ask him, but would you be surprised if $40,000 is the average charge in Lawnwood's region for those services?

A. You'd have to ask Mr. Sabolic.

Q. From your review of 300 hospital bills a year, would you be surprised it kind of falls in that ballpark as an average?

A. Hospital charges vacillate. That's my answer.

Q. There's a range?

A. There's a wide range.

Q. Would you be surprised that most providers charge less than stop loss than what Lawnwood did in this case?

A. There's a wide range down in that area.

Q. Do you have a sense of how many charge less and how many charge more than the stop loss?

A. No, sir.

Q. Have you ever been involved in any discussions within the division about outlier hospital charges?

A. I've heard the term. I do not remember what the reason was. I know we've discussed it over years. However, the statute rules -- and we have statutes and rules that we must follow.

Q. Okay.

A. And when it comes to disputes, I must follow them. And we see these not only in hospitals, but we also see these in ambulatory surgical centers.

Q. So this isn't an uncommon problem?

A. High charges.

Q. But I think the summation of it all is you're stuck with 75 percent or whatever the formula percentage of charged reimbursement is?

A. Any percent charge reimbursement basis.

MR. NEMECEK: Object to form on the phrase "stuck."

A. Pardon me?

Q. Okay. Do you see the word "stop loss," that term used anywhere in the statute?

A. No.

Q. Do you see the word "per diem" used in the statute?

A. Yes.

Q. Do you know if the statute was amended at any point in time as it relates to hospital inpatient charges and a per diem reimbursement?

A. It still states per diem methodology.

Q. Okay. Does it specifically say unless they can bill enough to beat the stop loss, then you go back to percentage of charges?

A. No.

Q. Did the division ever consider a Medicare-based reimbursement methodology for hospital surgeries that you know of?

A. I do not know, and you may want to ask Mr. Sabolic and the administration period.

Q. I'm going to wrap up shortly. So our bill here is about $164,000 for the finger surgery?

A. Approximately.

Q. If they added a zero to the end and it was $1.6 million, you're stuck with 75 percent of that; is that

correct?

MR. NEMECEK: Object to --

Q. (By Mr. Douglas) As long as it's in their chargemaster.

A. That is correct.

Q. So if they continue doubling their charges every two and a half to three years, five or six years from now, this charge will be a lot higher than it is today or than it was in 2016? Would you still be stuck with that as long as it's in their chargemaster?

MR. NEMECEK: Object to form.

A. If the statute remains the same, and the rule remains the same, the methodology would be mandated to follow through for reimbursement disputes.

Q. Does the -- since the DOAH final order in the rule challenge case that came out in late 2017, late November, what's your understanding of what that means as it relates to reimbursement contracts being interpreted or adjudicated by the division?

A. It means that the division may not make exceptions and not -- excuse me. Let's rephrase that.

It means the division must apply the terms of contracts, meaning if a contract is submitted we can validate that it is an effective contract for the date of service. We must apply it to the total correct

reimbursement based on the fee schedule.

Q. Has the division made you aware of any policies or procedures relating to what law of contract -- what contract law applies in adjudicating reimbursement contract disputes?

A. No.

Q. So if Florida law says that where a contract doesn't have a price you have to infer or determine a reasonable price, would you be able to apply that law to the contract reimbursement dispute?

A. We don't determine reasonableness. We must also follow the Florida statutes and rules. We apply the appropriate discount, or if there's a price we re-apply the price.

Q. And does the same thing apply to something you've heard before, 440 at .015 legislative intent of the statute for benefits, and -- it's a lot longer than this, but basically be provided to facilitate medical treatment and return to work to gainful employment at a reasonable cost to the employer, is there a rule that incorporates that legislative intent?

A. I'd have to say again, we don't determine reasonableness. We don't have a definition for that.

Q. Okay. So you don't have any way to do that?

A. No, sir.

MR. DOUGLAS: Okay. That's all I have. Thank you for your time.

THE WITNESS: Thank you.

MR. NEMECEK: No follow-up.

(The deposition was concluded at 10:32 a.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA)

COUNTY OF LEON)

I, the undersigned authority, certify that said designated witness personally appeared before me and was duly sworn.

WITNESS my hand and official seal this 14th day of September, 2018.

Steph Nargiz

STEPH JORDAN NARGIZ
Notary Public State of Florida
Comm# GG036664 Exp. 10/27/2020

CERTIFICATE OF REPORTER

STATE OF FLORIDA)

COUNTY OF LEON)

I, STEPHANIE JORDAN NARGIZ, court reporter and Notary Public do hereby certify that the foregoing proceedings were taken before me at the time and place therein designated; that a review of the transcript was requested, and that the foregoing pages numbered 1 through 57 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' attorneys or counsel connected with the action, nor am I financially interested in the action.

DATED this 22nd day of September, 2018.

Steph Nargiz

STEPH JORDAN NARGIZ
Court Reporter

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September 22, 2018

Lynne Metz
c/o Thomas Nemecek, Esquire and Tabitha Harnage, Esquire

In Re: September 14, 2018 deposition of Lynne Metz
Case: Zenith Insurance Company v. FDFS, Div. of Workers' Compensation, Office of Medical Services

Dear Ms. Metz:

This letter is to advise that the transcript for the above-referenced deposition has been completed and is available for your review and signature through Attorneys Thomas Nemecek and Tabitha Harnage, or if you wish, you may sign below to waive review of this transcript.

The original of this transcript has been forwarded to the ordering party and your errata, once received, will be forwarded to all ordering parties for inclusion in the transcript.

Sincerely,

Stephanie Jordan Nargiz
Court Reporter

cc: Ralph Douglas, Esquire
Thomas Nemeck, Esquire and Tabitha Harnage, Esquire

Waiver:
I, _____, hereby waive the reading and signing of my deposition transcript.

_____ _____
Deponent Signature Date

ERRATA SHEET

Under penalties of perjury, I declare that I have read the foregoing transcript of my deposition and hereby subscribe to same, including any corrections and/or amendments listed below.

Signature
ANDREW SABOLIC

Date

PAGE/LINE	ERROR OR AMENDMENT	REASON FOR CHANGE

Zenith Insurance Company v. Florida Department of Financial Services, Division of Workers' Compensation, Office of Medical Services
Reporter: Steph Jordan Nargiz
Date of deposition: 9/14/18