STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS
OFFICE OF THE JUDGES OF COMPENSATION CLAIMS
MIAMI DISTRICT OFFICE

Luis Rodriguez,
Employee/Claimant,

vs.

Demetech Corp./Normandy Harbor
Insurance Company,
Employer/Carrier/Servicing Agent.
_________________________________/

OJCC Case No. 14-028630SMS

Accident date: 8/5/2014

Judge: Sylvia Medina-Shore

FINAL EVIDENTIARY HEARING ORDER GRANTING CLAIMANT'S MOTION TO SELECT HIS ONE-TIME CHANGE IN PHYSICIAN UPON RE-HEARING

THIS CAUSE came before the undersigned Judge of Compensation Claims for an evidentiary hearing on 11/10/15 regarding claimant's motion to de-authorize and strike the opinions of Dr. Warren Grossman and award claimant a one-time change in spine surgeon of his choosing filed 9/3/15. The claimant is represented by David Benn, Esquire. The employer/carrier (E/C) are represented by Kurt Wirsing, Esquire. On 11/13/15, a final evidentiary hearing order was entered granting claimant's motion to strike opinions of Dr. Grossman and awarding claimant's request to select the one-time physician. On 11/23/15, E/C filed their motion for re-hearing and claimant his response in opposition thereto. In order to have sufficient time to address re-hearing arguments (some of which are quite lengthy), the undersigned entered an order on 11/24/15 vacating the 11/13/15 evidentiary hearing order. After carefully considering all the arguments, the evidence, and relevant case law, E/C's motion for re-hearing is denied.

Documentary Exhibits and Evidentiary Hearing Ruling:

JCC Exhibits-

1. Claimant requests judicial notice of the current procedural terminology (CPT) codes applicable to the instant medical fee payment issue. E/C objects contending the CPT codes are not capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned.
   Rule 69-7.020(2) incorporates and adopts the CPT 2009 codes, American Medical Association by reference as part of this rule. Rule 69-7020(1) adopts the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition, by reference as part of this rule. This Reimbursement Manual establishes polices, guidelines, codes and maximum reimbursement allowances for services and supplies provided by health care providers.
   I grant claimant's motion to take judicial notice of the CPT codes as incorporated in the Florida Workers' Compensation Health Care Provider Reimbursement Manual. To the extent which, if any CPT codes apply to the instant case, that is a matter requiring evidence and addressed below.

Joint Exhibits-

1. Deposition of Linda Hamilton (the adjuster) (DE#79 &80).
2. Response to PFB filed 9/4/15 (DE#59).

Claimant's Exhibits-

1. Claimant's motion to de-authorize and strike the opinions of Dr. Warren Grossman and award claimant a one-time change in spine surgeon of his choosing with attached discovery response (DE#58).
2. Payment agreement between Dr. Grossman (Orthopedic Associates of South

Broward) and USIS (DE#73).

3. Petition for benefits (PFB) filed 9/3/15 (DE#55).

4. Motion to compel, supplemental request to produce, and order (DE#50, 51, & 54).

Claimant's Proffer-

A. Deposition of Tamara Atkinson (office manager for Orthopedic Associates of South Broward) in the workers' compensation matter of Evelio Padron v. Majestic Mirror and Frame, LLC/Associated Industries of Florida 14-004606MGK (DE#72).

E/C's Exhibits-

1. E/C's corrected response in opposition to claimant's motion to de-authorize and strike with attachments (DE#71).

Findings of Fact and Conclusions of Law:

1. Aside from the deposition testimony, other admissible evidence and argument of counsels, there was no live testimony presented at the evidentiary hearing.

2. The following facts are undisputed: claimant requested a one-time change in orthopedic spine surgeon from Dr. Jonathan Hyde in written form on 4/6/15. On 4/7/15, E/C informed claimant in writing that Dr. Warren Grossman was being authorized as his one-time change in orthopedic spine surgeon. On same 4/7/15 date, Dr. Grossman provided the adjuster a letter of agreement wherein the carrier agreed to reimburse Orthopedic Associates of South Broward $850.00 for the first visit (for a second opinion, change of care or delayed care of an injury); $200.00 for follow-up visits; $200.00 per hour for film/record review; additional costs for x-rays performed in the office; and $275.00 disruption fee without 72 hour cancellation. The adjuster signed the agreement and faxed it to the doctor. There is no evidence claimant had

knowledge of the signed agreement at that time. Claimant attended an initial evaluation with Dr. Grossman on 6/9/15 and a follow-up visit on 8/21/15.

3. The evidence reflects claimant's attorney was provided with a payout on 7/27/15 (e-mail attached as exhibit "B" to E/C's response).

4. On 9/3/15, E/C filed their response to claimant's 7/8/15 request to produce, formally asserting "there are no specific written agreements between the carrier and Dr. Grossman regarding payment of his medical bills. Attached is everything in the carrier's file relating to Dr. Grossman's treatment and medical bills." Attached to the response were: explanation of bill review; health insurance claim form; 4/7/15 letter of agreement; and the medical reports of Dr. Grossman for 6/9/15.

5. On 9/3/15, claimant filed his motion to de-authorize and strike the opinions of Dr. Grossman and award claimant a one-time change of his choosing. Claimant argues E/C failed to authorize a one-time change in compliance with F.S. 440.13(13)(a) and (b)-payment of medical bills per the fee schedule in the Florida Workers' Compensation Health Care Provider Reimbursement Manual. E/C, on the other hand, argue claimant has not satisfied his burden of proof as to the overpayment of fees to Dr. Grossman; alternatively, claimant acquiesced to such overpayment by continuing to receive medical treatment and IIB benefits after having knowledge of the fee payment; and alternatively, if Dr. Grossman's opinions are stricken, E/C requests right to select new one-time change physician.

Issue -

6. Whether E/C properly authorized Dr. Grossman as claimant's one-time change in treating physician?

E/C's Re-hearing Lack of Jurisdiction Argument-

7. Upon re-hearing, E/C argue the undersigned lacks jurisdiction over the issue at hand because payment and/or overpayment of medical bills is a "reimbursement dispute" solely within the jurisdiction of the Agency for Healthcare Administration (AHCA). Claimant, on the other hand, points out the instant issue is not a "reimbursement dispute."

8. A "reimbursement dispute" is defined as "any disagreement between a health care provider . . . and carrier concerning payment of medical treatment." F.S. 440.13(1)(r). The disagreement in the present matter is not between Dr. Grossman and the carrier regarding payment for medical treatment. Rather, the issue is how payment in excess of the fee schedule to Dr. Grossman affects the "authorization" status of the physician, if at all. Thus, while medical fee reimbursement must be taken into account in the instant case, it is for the purpose of determining the authorization status of Dr. Grossman instead of determining compliance with the fee schedule or resolving dispute of alleged gouging. Accordingly, I find I have jurisdiction over the present matter. See, City of Riviera Beach v. Napier, 791 So.2d 1160 (Fla. 1st DCA 2001).

E/C's Re-hearing Lack of Standing Argument-

9. Next, E/C argue at re-hearing the claimant lacks standing to bring this "reimbursement dispute" before the undersigned as he is not being charged for Dr. Grossman's services. Claimant disagrees.

10. Case law has explained, in general terms, the duties and responsibilities of AHCA and the Judge of Compensation Claims (JCC). AHCA has the authority to establishing the fee schedule, determining compliance with the schedule, interpreting procedures under the schedule, and/or resolving disputes concerning gouging. A JCC's role encompasses assuring the injured claimant receives appropriate medical treatment, authorizes health care providers in disputes between the claimant and the employer/carrier, approves payment of medical bills

presented in proper form and resolves conflicts between healthcare providers as to the medical status of the claimant. See, Carswell v. Broderick Construction, 583 So.2d 803, 804 (Fla. 1st DCA 1991).

11. As mentioned above, the issue at hand is whether E/C properly authorized a one-time change of an authorized treating physician. I find this issue falls squarely within the undersigned's jurisdiction of authorizing health care providers in disputes between the claimant and E/C.

12. In order to address the above issue, the undersigned must determine whether E/C satisfied the requirements of F.S. 440.13 for authorizing medical care and treatment. The present request for authorization of medical care and treatment was made in the form of a "one-time" change. Therefore, the undersigned is guided by the language in F.S. 440.13(2)(f) and case law interpreting same. However, I find E/C's requirements in authorizing medical care and treatments are not restricted solely to F.S. 440.13(2)(f). Rather, I find E/C must also abide by F.S. 440.13(13)(a) and (b), applicable to medical services for remedial treatment, care, or attendance (except emergency care treatment) under chapter 440. Accordingly, while claimant is not being charged for Dr. Grossman's medical services, I find he has standing to bring forth the instant issue as it affects his medical care.

F.S. 440.13(13)(a) and (b)-

13. F.S. 440.13(13)(a) and (b) limits payment to health care providers or physicians to the applicable medical fee schedule and practice parameters and protocols, adopted under chapter 440 and department rule. A deviation from the applicable medical fee schedule is permitted if there is a written agreement wherein the health care provider agrees to follow identified procedures aimed at providing quality medical care to injured workers at reasonable costs.

14. After considering all the evidence, I find claimant has satisfied his burden of proof that Dr. Grossman charged and E/C impermissibly reimbursed the doctor for his services in excess of the applicable fee schedules. For the initial 6/9/15 visit, Dr. Grossman listed his charges including the CPT codes in the Health Ins. Claim Form. The carrier issued an Explanation of Bill Review listing same CPT codes and amounts paid for the services.

15. Page 41 of the Florida Workers' Compensation Health Care Provider Reimbursement Manual provides general instructions on maximum reimbursement allowances. In the case at hand, I find Part C of Section XI of the Manual applies as the initial visit dealt non-surgical services provided by a Florida physician (Dr. Grossman). The location of service was in Broward County and therefore, "Locality 03" applies to the instant case.

16. The 6/9/15 office visit qualifies under a non-facility MRA (services rendered in a provider's office, urgent care center or diagnostic facility). However, whether this visit is considered a non-facility MRA or a facility MRA (services rendered in a hospital setting, ambulatory surgical center, skilled nursing facility, inpatient psychiatric facility, and comprehensive Level III outpatient rehabilitation facility), I find it irrelevant in the instant case as the amount charged and paid to Dr. Grossman exceeds the maximum fee allowable under both categories. The maximum fee allowable for the initial visit under CPT code 99205, Locality 03 (Non-Facility MRA) is $198.00 and under Locality 03 (Facility MRA) is $162.00. Dr. Grossman charged and E/C paid him $850.00 (CPT code 99205).

17. Likewise, as it relates to records review (CPT code 99358); the maximum reimbursement allowed is $106.00. Dr. Grossman charged and E/C paid $150.00. As it relates to review of studies (CPT code 72120), the maximum reimbursement allowed is $56.00. Dr. Grossman charged and E/C paid $155.00. Another review of studies (CPT code 72100) was paid at $125.00 when the maximum fee allowed is $44.00. Lastly, the radiologic examination

pelvis 1/2 views was billed out and paid at $96.00 when the maximum reimbursement allowed is $31.00.

18. The adjuster testified she did not know the medical fee schedules for the above medical bills as the Bill Review Department handles processing of the doctor's bills. However, I find the evidence namely the letter agreement, the health insurance form provided by the doctor, and the explanation of bill review issued by the carrier all support E/C *knowingly* paid Dr. Grossman in excess of maximum fee schedule. Specifically, the carrier notes in the explanation of bill review that no modification was made to Dr. Grossman's bill as payment was made pursuant to a fee agreement between the health care provider and the carrier.

19. Further, I find the adjuster's lack of knowledge of the medical fee reimbursement schedule is no excuse for E/C failing to abide with F.S. 440.13(13)(a) and (b). The employer and/or carrier are solely responsible for authorization and payment of medical care. The carrier is deemed to possess knowledge of the requirements of the law, including F.S. 440.13(13)(a) and (b). In the present case, the adjuster (not the bill review company) entered into the letter agreement with Dr. Grossman regarding payment for medical services in excess of the fee schedule. Contrary to E/C's factual statement in his motion for re-hearing, this medical fee agreement was entered into between Dr. Grossman and the carrier ***within*** 5 days from claimant's request for the one-time change. Accordingly, in failing to abide by the requirements of F.S. 440.13(13)(a) and (b), I find E/C did not properly authorize Dr. Grossman as claimant's one-time change.

Deviations from the Statutory Fee Schedule-

20. F.S. 440.13 (13)(b) allows deviations from established fee schedules if the provider specifically agrees in writing to follow certain identified procedures aimed at providing quality medical care to injured workers at reasonable costs. However, I find the letter

agreement does not satisfy the above requirements nor is there evidence of a separate written agreement and/or testimony supporting a finding that the amounts charged by Dr. Grossman warranted a deviation from the fee schedule.

E/C's defense that Claimant Acquiesced to Payment of Dr. Grossman's Bills in Excess of Fee Schedule-

21. E/C argues claimant acquiesced to the payment arrangement with Dr. Grossman by having knowledge of said overpayment in July of 2015 and yet, attending an FCE appointment and 8/21/15 visits. I reject E/C's argument.

22. While Mr. Benn had the payout sheet in his possession in July of 2015 reflecting a $1,476.00 payment to the medical group of Dr. Grossman, the payout sheet failed to include the itemized charges per service. The $1,476.00 amount encompasses 6 of the doctor's charges, not itemized or explained in the payout sheet. The payout sheet does not list the CPT codes either.

23. I find the first occasion claimant had sufficient knowledge of the amounts charged and services rendered by Dr. Grossman was on 9/3/15 when Mr. Benn received the letter agreement, health insurance claim form and explanation of bill review. Claimant then timely filed his objections on same date.

E/C's Request to Select Another One-Time Change in Physician-

24. In the alternative, E/C requests the right to select another treating physician as claimant's one-time change. Since Dr. Grossman was timely authorized, E/C argue they keep the right of selection as to the one-time change. See, F.S. 440.13(2)(f). I reject E/C's argument as not supported by the law.

25. Dr. Grossman was offered as claimant's one-time change in treating physician. E/C selected Dr. Grossman. E/C had knowledge and agreed to Dr. Grossman's required charges

well within the 5- days of the request for the one-time change. E/C had the opportunity of securing the required written agreement allowing for a fee deviation or authorizing another treating doctor willing accept payment per the fee schedule. They did not do so. Because E/C's authorization of Dr. Grossman failed to comply with F.S. 440.13(13)(a) and (b), I find said authorization was *void ab initio*. In turn, because Dr. Grossman is not an authorized healthcare provider, I find E/C failed to comply with F.S. 440.13(2)(f) which requires the "authorization" of an alternate physician within five (5) days. Accordingly, I find claimant has the right of selection of his one-time change and deny E/C's request.

26. E/C and claimant argue, on re-hearing, about respective public policy concerns regarding right of selection, authorization and payment of treating physicians. The undersigned is mindful of chapter 440's intent and case law providing E/C with the right to control medical care. In fact, F.S. 440.13(2)(f) provides said medical control to the E/C.

27. However, I find E/C's right to control medical care is not absolute. In order for E/C to retain their right of control over medical care, they must abide by chapter 440. In the present case, the E/C have unclean hands from the onset of authorization of Dr. Grossman and now desire a "do over." Allowing this "do over" is contrary to the mandates of F.S. 440.13(2)(f) and further rewards E/C for their non-compliance with F.S. 440.13(13)(a) and (b). In awarding claimant the right to select the one-time change, I do so based on the statutory authority provided by F.S. 440.13(2)(f) and F.S. 440.13(13)(a) and (b), and not as a sanction.

28. Claimant requests the undersigned to de-authorize Dr. Grossman. This is not possible because I find Dr. Grossman was never properly authorized. Claimant also seeks to strike the opinions of Dr. Grossman. However, Dr. Grossman's opinions are not being introduced into evidence at this point in time. Therefore, I find admissibility of Dr. Grossman's opinions is an issue which will be ripe for an evidentiary hearing, when his opinions are being

sought to be introduced into evidence. His factual testimony may be admissible, again at an evidentiary hearing.

WHEREFORE, IT IS ORDERED:

1. Motion to award claimant a one-time change in spine surgeon ***of his choosing*** is granted.
2. Claimant shall select a one-time change in spine surgeon and provide E/C with the information so an appointment may be scheduled.

DONE AND E-MAILED TO THE ATTORNEYS OF RECORD AND THE CARRIER THIS 25TH DAY OF NOVEMBER OF 2015. THE ATTORNEYS SHALL PROVIDE A COPY OF THE INSTANT ORDER TO THEIR RESPECTIVE CLIENTS UPON RECEIPT OF SAME.

Sylvia Medina-Shore
Judge of Compensation Claims

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