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 Nos. 17-3025RP
17-3026RP
DEPARTMENT OF FINANCIAL SERVICES, DIVISION OF WORKERS' COMPENSATION, 17-3027RP

Respondent,

and

ZENITH INSURANCE COMPANY; BRIDGEFIELD EMPLOYERS INSURANCE COMPANY; BRIDGEFIELD CASUALTY INSURANCE COMPANY; BUSINESSFIRST INSURANCE COMPANY; AND RETAILFIRST INSURANCE COMPANY,

Intervenors.
_____/

FINAL ORDER

Pursuant to notice, the final hearing in these consolidated cases was held on October 11 and 12, 2017, before Elizabeth McArthur, Administrative Law Judge, Division of Administrative Hearings (DOAH), in Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues to be determined are: whether Petitioners have standing; whether the petition of Automated HealthCare Solutions, Inc. (AHCS), was timely filed[1/]; and whether Respondent's proposed rules 69L-31.005(2)(d), 69L-31.016(1), and 69L-31.016(2) are invalid exercises of delegated legislative authority on the grounds raised by Petitioners.

PRELIMINARY STATEMENT

On May 22, 2017, the Florida Society of Ambulatory Surgical Centers, Inc. (FSASC), filed a petition challenging proposed rule 69L-31.016(1) as an invalid exercise of delegated legislative authority, on the grounds set forth in section 120.52(8)(b) and (c), Florida Statutes (2017)[2/] (exceeds the cited statutory grant of rulemaking authority; enlarges, modifies, or contravenes the cited law implemented). The petition also challenged the validity of proposed rule 69L-31.005(2)(d) as arbitrary and capricious pursuant to section

120.52(8)(e).[3/] The FSASC proposed rule challenge was assigned DOAH Case No. 17-3025RP.

Also on May 22, 2017, HCA Health Services of Florida, Inc., d/b/a Oak Hill Hospital (Oak Hill), and HSS Systems, LLC, d/b/a Parallon Business Performance Group (Parallon), filed a petition challenging the validity of proposed rule 69L-31.016(1), on the grounds that it enlarges, modifies, and contravenes the cited law implemented. The Oak Hill/Parallon petition also challenged the validity of proposed rule 69L-31.016(1) pursuant to sections 120.52(8)(a) and (f) and 120.541, based on an alleged material failure to follow rulemaking procedures related to statements of estimated regulatory costs (SERC), and the failure to adopt a less costly regulatory alternative (LCRA) that substantially accomplishes the statutory objectives. The Oak Hill/Parallon proposed rule challenge was assigned DOAH Case No. 17-3026RP.

On May 23, 2017, AHCS filed a petition challenging the validity of proposed rule 69L-31.016(2), on all grounds set forth in section 120.52(8). The AHCS proposed rule challenge was assigned DOAH Case No. 17-3027RP.

On May 26, 2017, the three cases were assigned to Administrative Law Judge D. R. Alexander, who set them for separate hearings on June 22, 23, and 26, 2017.

On June 7, 2017, Petitioners filed a joint motion to consolidate and continue the final hearings, which was granted, and a one-day hearing was set for July 14, 2017.

On June 8, 2017, a joint motion to intervene to support the challenged proposed rules was filed by Zenith Insurance Company (Zenith), Bridgefield Employers Insurance Company (BEIC), Bridgefield Casualty Insurance Company (BCIC), BusinessFirst Insurance Company (BFIC), and RetailFirst Insurance Company (RFIC) (collectively, Intervenors).

Petitioners filed a second motion for continuance on June 22, 2017, based on the need for more than one hearing day and the need to resolve discovery disputes. The motion was granted, and the hearing was reset for October 11 and 12, 2017.

On October 2, 2017, the parties filed a Joint Prehearing Stipulation, in which they stipulated to many facts. The stipulated facts are incorporated below to the extent relevant.

On October 4, 2017, the consolidated cases were transferred to the undersigned.

On October 10, 2017, Respondent filed motions to dismiss the petitions for lack of standing. The motions were denied by Order issued on October 11, 2017.

At the final hearing, the parties offered Joint Exhibits 1 through 53, which were admitted in evidence.

Petitioner AHCS presented the testimony of Brenda Velazquez, vice president of the revenue cycle department, and Andrew Sabolic, assistant director of the Division of Workers' Compensation. AHCS's Exhibits AH1 and AH9 were admitted; Exhibits AH3 through AH6 were admitted for the purpose of illustrating examples of determinations made before and after implementation of policies now proposed for rule adoption.

Petitioner FSASC presented the testimony of Peter Lohrengel, FSASC's executive director. FSASC's Exhibits FS1 through FS3 were admitted as examples of determinations made before and after implementation of policies now proposed for rule adoption.

Petitioners Oak Hill and Parallon presented the testimony of Tiffany Taylor, a Parallon senior underpayments analyst, and Beverly Michelle Harvey, the controller at Oak Hill. Oak Hill/Parallon Exhibits OH/P3 and OH/P4 were admitted.

Respondent presented the testimony of Andrew Sabolic. Respondent's Exhibit DWC1 was admitted. Respondent's Exhibits DWC4 through DWC6 (summaries of proposed rule comments) were admitted for the limited purpose of showing the rulemaking process, and not for the truth or accuracy of the summaries.

Intervenor Zenith presented the testimony of Carol Brodie, a Zenith bill review attorney. Zenith Exhibit ZEN1 was admitted.

Intervenors BEIC, BCIC, BFIC, and RFIC (collectively, the Summit Companies) presented the testimony of Merri Moats, the provider network director for Summit Consulting, LLC. The Summit Companies offered Exhibit SUM2 into evidence, but relevancy objections were sustained, and it was not admitted.

A transcript was ordered. To avoid the expense of a very-expedited transcript, the parties agreed on the record to a limited waiver of the statutory deadline for issuance of a final order within 30 days after the hearing. See § 120.56(1)(d), Fla. Stat. To adhere to that deadline, the parties would have been required to file proposed final orders (PFOs) 10 days after the final hearing, and in order to provide appropriate record citations, they would have needed an immediate transcript. Instead, it was agreed that the filing deadline for PFOs would be 10 days after the filing of the transcript, and a final order would be issued within 20 days after the filing of the PFOs.

The three-volume Transcript of the final hearing was filed on October 31, 2017. The parties filed their PFOs on November 13, 2017.[4/] Petitioners filed a "corrected" PFO on November 14, 2017, with no obvious indicator as to what was "corrected." Nonetheless, no party objected to the corrected PFO, and it is accepted. The PFOs have been given due consideration in the preparation of this Final Order.

FINDINGS OF FACT

The Challenged Proposed Rules

1. At issue in the proposed rule challenge proceeding are three provisions that are part of an overall rulemaking exercise by Respondent Department of Financial Services, Division of Workers' Compensation (Respondent, Department, or Division), to amend Florida Administrative Code Chapter 69L-31. That rule chapter bears the misnomer "Utilization and Reimbursement Dispute Rule"--a misnomer because, rather than a single rule, the chapter currently contains 12 rules, with a history note of one additional rule that was repealed.

2. The existing 12 rules in chapter 69L-31, in effect without amendment since November 2006, carry out the Department's statutory authority to receive, review, and resolve reimbursement disputes between workers' compensation insurance carriers (carriers) and providers of health care services, medication, and supplies to injured workers. See § 440.13(7), Fla. Stat. A "reimbursement dispute" is "any disagreement" between a provider and carrier "concerning payment for medical treatment." § 440.13(1)(q), Fla. Stat.

3. The proposed amendments to chapter 69L-31 include revisions to existing rules, the repeal of one existing rule, and the addition of two new rules. The challenges at issue here are directed to both paragraphs of a newly proposed rule which

would become rule 69L-31.016, if adopted. One challenge is also directed to an amendment of an existing rule.

4. Proposed rule 69L-31.016, entitled "Reimbursement Disputes Involving a Contract or Workers' Compensation Managed Care Arrangement or Involving Compensability or Medical Necessity," would provide as follows, if adopted:

> (1) When either the health care provider or carrier asserts that a contract between them establishes the amount of reimbursement to the health care provider, or where the carrier provided health care services to the injured worker through a workers' compensation managed care arrangement pursuant to Section 440.134, F.S., the Department will not issue a finding that there has been any improper disallowance or adjustment. Instead, the determination will only indicate the reimbursement amount for the treatment established by the appropriate reimbursement schedules, practice parameters, and protocols of treatment in Chapter 440, F.S., to assist the health care provider and carrier in their independent application of the provisions of the contract or workers' compensation managed care arrangement to resolve the dispute.
>
> (2) When the carrier asserts the treatment is not compensable or medically necessary and as a result does not reimburse, the determination will only address line items not related to compensability or medical necessity. If the petitioner has submitted documentation demonstrating the carrier authorized the treatment, the Department will issue a finding of improper disallowance or adjustment.

5. Although these rules were not proposed for adoption until December 2016, Respondent has been implementing an

unadopted policy that is consistent with paragraph (1) since August 2015. Respondent also has been implementing an unadopted policy that is similar to paragraph (2) since November 2015.

6. The other object of challenge is the proposed deletion of rule 69L-31.005(2)(d), which currently provides:

> If the answer to question 5 on the Petition for Resolution of Reimbursement Dispute Form [asking if reimbursement is pursuant to a contract or rate agreement] is yes, [submit] a copy of all applicable provision(s) of the reimbursement contract.

Although the evidence was less than clear, it does not appear that Respondent is already implementing this proposed change.

The Parties

7. Petitioners and Intervenors all are regular participants (or, in the case of FSASC, an association whose members are regular participants) in provider-carrier reimbursement disputes pursuant to section 440.13(7), Florida Statutes, before the Division. Petitioners represent the provider side of these reimbursement disputes, while Intervenors represent the carrier side of the reimbursement disputes.

8. Petitioner Oak Hill is a private, for-profit hospital that cares for thousands of Florida patients each year, including injured workers.

9. Petitioner Parallon provides revenue cycle services for HCA-affiliated Florida hospitals, including Oak Hill. Among

other things, Parallon acts on behalf of the HCA-affiliated hospitals in workers' compensation claim disputes. Parallon acts on the hospitals' behalf to resolve reimbursement disputes with carriers, including: acting for the hospitals to resolve reimbursement disputes under chapter 69L-31; coordinating any resultant administrative litigation before DOAH; and taking steps necessary to collect amounts owed following receipt of the Division's determination. Parallon is expressly authorized to participate in reimbursement disputes as a "petitioner," as defined in proposed rule 69L-31.003, on behalf of Oak Hill and other HCA-affiliated hospitals. Oak Hill and Parallon are regulated by, and must comply, with the requirements of chapter 69L-31 (which will include the proposed rules, if adopted) in reimbursement disputes with carriers.

10. Petitioner FSASC is the primary organization of ambulatory surgical centers (ASCs) in Florida. Among the purposes of the FSASC is to advance the ASC industry, and its member centers' interests, through governmental advocacy. To that extent, the FSASC maintains close contact with state agencies to monitor and provide input into legislation and regulations that govern or affect ASC operations. In furtherance of this role, the FSASC has been an active participant in all phases of Respondent's rulemaking efforts with regard to the proposed rules.

11. Another purpose of the FSASC is to promote, assist, and enhance its members' ability to provide ambulatory surgical services to injured workers efficiently and cost effectively throughout Florida and, in so doing, promote and protect the interests of the public, patients, and FSASC members.

12. FSASC's participation in this proceeding is consistent with its purposes, and the relief sought--invalidation of the challenged proposed rules (with possible attorney's fees incurred in connection with this proceeding)--is appropriate for an organization to pursue in a representative capacity.

13. A substantial number of FSASC's members provide health care services to patients who are injured workers in Florida and who receive workers' compensation benefits in accordance with chapter 440. These health care services are reimbursable by the patients' employers' carriers. FSASC's members are participants in reimbursement disputes with carriers and are regulated by, and must comply with, the requirements of chapter 69L-31 (which will include the proposed rules, if adopted).

14. Petitioner AHCS is a technology and prescription medication claims processing company. Many physicians who dispense medication from their offices to injured workers assign their rights, title, and interest to the prescription medication claims to AHCS. Prescription Partners, LLC, is wholly-owned and operated by AHCS and is the billing entity of AHCS. In some

instances, AHCS contracts with physicians, while Prescription Partners, LLC, pursues the billing and reimbursement disputes on behalf of the physicians under the contract of assignment. AHCS is authorized to participate in reimbursement disputes as a "petitioner," as defined in proposed rule 69L-31.003. As a participant in reimbursement disputes, AHCS is regulated by, and must comply with, the requirements of chapter 69L-31 (which will include the proposed rules, if adopted).

15. Respondent is the state agency tasked with administering chapter 440 in a way that promotes "an efficient and self-executing" workers' compensation system "which is not an economic or administrative burden" and ensures "a prompt and cost-effective delivery of payments." § 440.015, Fla. Stat. The Division's medical services section administers the provider-carrier reimbursement dispute process and issues the required determinations pursuant to section 440.13(7). The determinations are made in accordance with chapter 440 and the applicable reimbursement manuals, which are codified as rules.

16. Intervenor Zenith is a foreign, for-profit corporation licensed by the Department to provide workers' compensation insurance to employers throughout Florida. As a carrier, and in the normal course of its workers' compensation claim-handling responsibilities, Zenith regularly authorizes, adjusts, and pays for medical benefits for injured workers for causally-related

and medically necessary treatment, including treatment rendered by physicians, hospitals, ASCs, pharmacies and prescription drug vendors, physical therapists, and other licensed health care providers, such as Petitioners.

17. As a carrier, Zenith is regulated by chapter 440 and the related rules of the Division, including chapter 69L-31 (which will include the proposed rules, if adopted).

18. All parties stipulated that the challenged proposed rules directly and immediately affect the rights and obligations of Zenith, and directly impact the financial obligations of Zenith in medical bill payment, as well as in any statutory reimbursement dispute between a health care provider and Zenith under section 440.13(7). The proposed rules dictate which processes will govern reimbursement disputes involving Zenith, and whether Zenith may rely fully on the provisions of reimbursement contracts.

19. Intervenors, the Summit Companies, are Florida-licensed monoline workers' compensation insurance companies that are managed by a managing general agent, Summit Consulting LLC, and regulated by the Department. Pursuant to their workers' compensation insurance policies, the Summit Companies pay workers' compensation claims for injured workers, including payment of medical benefits for care provided to injured workers by health care providers who have filed petitions for

reimbursement dispute resolution under chapter 69L-31. Also, the Summit Companies have a workers' compensation managed care arrangement authorized by the Agency for Health Care Administration (AHCA) pursuant to section 440.134. Their delegated managed care entity, Heritage Summit HealthCare, LLC, has its own proprietary PPO network.

20. The Summit Companies, either corporately or through their delegated managed care entity, regularly authorize, adjust, and pay medical benefits for injured workers for causally-related and medically necessary treatment, including payment for treatment rendered by physicians, hospitals, ASCs, pharmacies and prescription drug vendors, physical therapists, and other licensed health care providers, such as Petitioners.

21. All parties stipulated that the challenged proposed rules directly and immediately affect the rights and obligations of the Summit Companies, and directly impact their financial obligations in medical bill payment, as well as in reimbursement disputes under section 440.13(7) and chapter 69L-31. The proposed rules dictate which processes will govern reimbursement disputes involving the Summit Companies, including whether the Summit Companies may rely on their managed care arrangements and contracts regulated under the authority of AHCA.

22. To the same extent that all Intervenors are directly and immediately impacted by the challenged proposed rules,

Petitioners Oak Hill, Parallon, and AHCS, as well as the members of Petitioner FSASC, are also directly and immediately impacted by the proposed challenged rules, which govern reimbursement disputes under section 440.13(7). Just as the challenged proposed rules directly and immediately impact Intervenors' financial obligations in medical bill payment to providers, such as Petitioners, the challenged proposed rules also directly and immediately impact Petitioners' financial rights in having medical bills paid by carriers, such as Intervenors. The challenged proposed rules dictate what processes will be available in reimbursement disputes, not only for Intervenors, but for Petitioners. The challenged proposed rules dictate when the cost-efficient reimbursement dispute process will be, and will not be, fully available to Petitioners and FSASC's members, and when the prompt delivery of payment envisioned as the end result of the reimbursement dispute process will, or will not be, available to them.

23. The parties also stipulated that the Division's challenged proposed rules immediately and substantially affect Intervenors because prior authorization, the managed care defense, provider contract disputes, and medical necessity all have been raised as issues in prior chapter 69L-31 provider disputes with these carriers. It stands to reason that the providers who are on the other side of these disputes with

carriers are just as immediately and substantially impacted by the proposed rules in this regard.

24. Reason aside, Respondent readily stipulated to the direct, immediate, and substantial impacts to Intervenors, but steadfastly disputed that Petitioners (or the members of Petitioner FSASC) must necessarily be impacted to the same degree. Yet they are, after all, the other side of the reimbursement dispute coin. It is difficult to understand how one side of a dispute could be directly, immediately, and substantially impacted by proposed rules regulating the dispute process, while the other side of the dispute would not be equally impacted. At hearing, the undersigned raised this seeming incongruity, and suggested that Respondent would need to explain its different positions with regard to the factual predicates for standing for Intervenors and for Petitioners, besides the obvious difference that Intervenors were supporting Respondent's proposed rules while Petitioners were challenging them. Respondent offered no explanation for its incongruous positions, either at hearing or in its PFO. Respondent's agreement that Intervenors are immediately, directly, and substantially affected by the challenged proposed rules serves as an admission that Petitioners (or Petitioner FSASC's members) are also immediately, directly, and substantially affected by the challenged proposed rules.

25. Specific examples were offered in evidence of the Division's refusal to resolve reimbursement disputes because contracts and managed care arrangements were involved, or because payment was adjusted or disallowed due to compensability or medical necessity issues. FSASC provided a concrete example of the application of the unadopted policies to one of its members, resulting in immediate injury when the Division refused to resolve a reimbursement dispute because a contract was involved. Petitioner Oak Hill identified a single reimbursement dispute over a $49,000 underpayment that remained unresolved because of the Division's refusal to resolve the dispute because either a contract or managed care arrangement was involved. Petitioner Parallon's income is based, in part, on paid claims by carriers, so it loses income when these reimbursement disputes are not resolved and the carriers are not ordered to promptly pay an amount. Petitioner AHCS offered examples of reimbursement disputes that the Division refused to resolve because the carrier disallowed or adjusted payment due to compensability or medical necessity issues. AHCS also noted that the incidence of carrier disallowances and adjustments of payment for compensability and medical necessity reasons has increased since the Division stopped making determinations to resolve reimbursement disputes on those issues.

26. At the very least, Petitioners have already been harmed in these ways: by the delay in resolving reimbursement disputes, which includes lost cash flow and the time value of the money that carriers are not ordered to pay; by the increased personnel costs necessary to try some other way to pursue these claims; and by the prospect of court filing fees and attorney's fees to try to litigate their right to payment when deprived of the statutory mechanism for cost-efficient resolution of reimbursement disputes. Conceivably, providers will not have recourse in court to contest disallowance or adjustment of payment, given Respondent's exclusive jurisdiction to decide any matters concerning reimbursement. § 440.13(11)(c), Fla. Stat.

27. Meanwhile, carriers immediately benefit from delay, by not being ordered to promptly pay claims. In an annual report addressing reimbursement dispute determinations for the fiscal year from July 1, 2015, through June 30, 2016, the Division reported that in 85.5 percent of its reimbursement dispute determinations, it determined that the health care providers had been underpaid.

Overview of Workers' Compensation Reimbursement Dispute Process

28. Under Florida's statutory workers' compensation system, injured workers report their injury to the employer and/or the carrier.

29. With an exception for emergency care, a health care provider must receive authorization for treatment from the carrier prior to providing treatment.

30. After providing treatment, health care providers, including hospitals and physicians, must submit their bills to employers' carriers; they are prohibited from billing the injured employees who received the treatment. These bills typically have multiple line items, such as for pharmaceutical prescriptions, diagnostic tests, and other services rendered.

31. Carriers are required to review all bills submitted by health care providers to identify overutilization and billing errors, and to determine whether the providers have complied with practice parameters and protocols of treatment established in accordance with chapter 440. § 440.13(6), Fla. Stat.

32. Mr. Sabolic explained that the "protocols of treatment" are the standards of care in section 440.13(15). These include criteria for "[r]easonable necessary medical care of injured employees." § 440.13(15)(c), Fla. Stat.

33. The carrier review of provider bills must culminate in a determination of whether the bill reflects overutilization of medical services, whether there are billing errors, and whether the bill reflects any violations of the practice parameters and protocols of treatment (standards of care). If a carrier finds any of these to be the case, the carrier is required by statute

to disallow or adjust payment accordingly. The carrier is expressly authorized to make this determination "without order of a judge of compensation claims or the department," if the carrier makes its determination in compliance with section 440.13 and Department rules. § 440.13(6), Fla. Stat.

34. The Department's rules require carriers to communicate to providers the carriers' decisions under section 440.13(6) to pay or to deny, disallow, or adjust payment, with reasons for their decisions, in an "explanation of bill review" (EOBR).[5/]

35. If a carrier contests or disputes certain line items on a medical bill, the EOBR must identify the line items disputed and the reasons for the dispute, using EOBR codes and code descriptor. The EOBR code list, with 98 codes and descriptors, is set forth in Florida Administrative Code Rule 69L-7.740(13)(b). All but two of the codes describe reasons for disallowing or adjusting payment. EOBR Code 10 means payment denial of the entire bill, when the injury or illness is not compensable. EOBR Code 11 is used for partial denial of payment, where, although there is a compensable injury or illness, a diagnosis or procedure code for a particular line item service is determined by the carrier to be unrelated to the compensable condition.

36. The EOBR coding rule provides that up to three codes can be assigned to each line item to "describe the basis for the

claim administrator's reimbursement decision in descending order of importance[.]" In addition, there is a "free-form" box in which additional notes of explanation may be given.

37. The carrier's determination to disallow or adjust payment of a health care provider's bill, made pursuant to section 440.13(6), and explained to the health care provider by means of an EOBR, is the action that sets up a potential reimbursement dispute pursuant to section 440.13(7).

38. "Any health care provider who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 45 days after receipt of notice of disallowance or adjustment of payment, petition the department to resolve the dispute." § 440.13(7)(a), Fla. Stat. (emphasis added). The petition must be accompanied by "all documents and records that support the allegations in the petition." Id.

39. The carrier whose EOBR is disputed "must" then submit to the Department within 30 days of receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. § 440.13(7)(b), Fla. Stat.

40. Section 440.13(7)(c) and (d) provide for the culmination of the reimbursement dispute process, as follows:

> (c) Within 120 days after receipt of all documentation, the department must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or

> disallowed payment. 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 rendering its determination.
>
> (d) If the department finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within 30 days, subject to the penalties provided in this subsection. (emphasis added).

41. Section 440.13(7)(e) provides that the Department "shall adopt rules to carry out this subsection," i.e., the reimbursement dispute process. As noted, the Department did so in 2006, in promulgating chapter 69L-31. The rules were transferred from AHCA, which was the state agency vested with the statutory authority to determine reimbursement disputes between providers and carriers until the Department took over those functions in 2005.[6/]

Evolution of the Policies in the Challenged Proposed Rules

A. Reimbursement Pursuant to a Provider-Carrier Contract or Managed Care Arrangement

42. For approximately a decade, the Division accepted petitions to resolve reimbursement disputes when the reimbursement amount was determined by a contract between the provider and carrier. The Division resolved these disputes by issuing written determinations of whether the carrier properly adjusted or disallowed payment, and if the Division determined

the carrier improperly adjusted or disallowed payment, the Division would specify the contract reimbursement amount that the carrier was required to pay within 30 days. That is because section 440.13(12) expressly recognizes that reimbursement to providers shall be either an amount set as the maximum reimbursement allowance (MRA) in fee schedules (or other amount set by a statutory formula), or the agreed-upon contract price.[7/]

43. Health care network reimbursement contracts typically do not (but may) include prices stated in dollar amounts. Instead, they frequently establish the price for reimbursement as a percentage of the MRA, or a percentage of allowable charges for services rendered.

44. The Division's reimbursement manuals in effect today, adopted as rules, recognize in a variety of contexts that the amount a provider is to be reimbursed is the contract amount, when there is a contract between the provider and carrier. The Workers' Compensation Health Care Provider Reimbursement Manual currently in effect provides this introductory statement:

> Reimbursement will be made to a Florida health care provider after applying the appropriate reimbursement policies contained in this Manual.
>
> A carrier will reimburse a health care provider either the MRA in the appropriate reimbursement schedule or a mutually agreed upon contract price. (emphasis added).

Florida Workers' Compensation Health Care Provider Reimbursement Manual (2016 edition) at 15, adopted and incorporated by reference in rule 69L-7.020, effective July 1, 2017. The manual has dozens of references to reimbursing at the contract price, such as this example for reimbursement for multiple surgeries:

> Reimbursement for the primary surgical procedure will be the MRA listed in Chapter 3, Part B of this Manual or the agreed upon contract price.
>
> Reimbursement for additional surgical procedure(s) will be fifty percent (50%) of the listed MRA in Chapter 3, Part B of this Manual or the agreed upon contract price.
>
> * * *
>
> Note: If there is an agreed upon contract between the health care provider and the carrier, the contract establishes the reimbursement at a specified contract price. (emphasis added).

Id. at 63.

45. Similarly, the ASC reimbursement manual in effect has multiple references to reimbursement at the contract price or contract amount, such as this example for surgical services:

> For each billed CPT® code listed in Chapter 6 of this Manual, the ASC shall be reimbursed either:
> • The MRA if listed in Chapter 6 of this Manual; or
> • The agreed upon contract price.
>
> For each billed CPT® code not listed in Chapter 6 of this Manual, the ASC shall be reimbursed:

> • Sixty percent (60%) of the ASC's billed charge; or
> • The agreed upon contract price.
>
> * * *
>
> Note: If there is an agreed upon contract between the ASC and the carrier, the contract establishes the reimbursement at the specified contract price. (emphasis added).

Florida Workers' Compensation Ambulatory Surgical Center Reimbursement Manual (2015 edition) at 17, incorporated by reference in rule 69L-7.020, effective January 1, 2016. See also ASC Manual App. A at 1 (surgical implant MRA is "50% above acquisition cost; amount certified or contract amount.").

46. The reimbursement manual for hospitals has similar references, including this directive for inpatient services:

> Except as otherwise provided in this Manual, charges for hospital inpatient services shall be reimbursed according to the Per Diem Fee Schedule provided in this Chapter or according to a mutually agreed upon contract reimbursement agreement between the hospital and the insurer. (emphasis added).

Florida Workers' Compensation Reimbursement Manual for Hospitals (2014 edition) at 15, adopted and incorporated by reference in rule 69L-7.501, effective January 1, 2015.

47. In 2013, the Division submitted a legislative proposal for the Department to consider including in its proposed bill. The Division requested an amendment to section 440.13 to "[r]emove contracted reimbursement from [reimbursement dispute]

resolution authority of [the] department." Jt. Ex. 51 at 1. That proposal did not lead to a statutory change.

48. An example of how the Division resolved reimbursement disputes involving contracts before its recent policy is shown in Exhibit FS1, a "Resolution of Reimbursement Dispute Determination." According to the document, at issue was a reimbursement dispute regarding a bill for one service, for which the carrier issued an EOBR disallowing payment. The Division's finding regarding reimbursement was that the contract at issue "provides for reimbursement at the lesser of 90% of billed charges or 90% of the fee schedule." The Division calculated the contract price and determined that the "total correct reimbursement amount" per the contract was $2,334.60. The determination, issued June 30, 2015, was:

> The Department of Financial Services, Division of Workers' Compensation has determined that the petitioner substantiated entitlement to additional reimbursement of disputed services based upon the documentation in evidence and in accordance with the provisions of the Florida Workers' Compensation Reimbursement Manual [for ASCs], 2011 Edition, Chapter 3, page 26.
>
> The respondent shall remit the petitioner the amount of $2,334.60 and provide the Division proof of reimbursement to the petitioner within thirty (30) days of receipt of this notice[.]

Ex. FS1 at 2.

49. The evolution was a little different for reimbursement disputes involving workers' compensation managed care arrangements. Rule 69L-31.015, adopted by the Department in 2006, provided as follows:

> A health care provider may not elect to contest under Section 440.13(7), F.S., disallowance or adjustment of payment by a carrier for services rendered pursuant to a managed care arrangement.

Mr. Sabolic explained that while this rule was in effect, the Division would dismiss petitions that disclosed managed care arrangements. But the rule was repealed in response to a challenge to the rule's validity. As Mr. Sabolic recalled it, the challenger was Parallon or an individual HCA-affiliated hospital. According to Mr. Sabolic, the Division agreed that it did not have the authority to simply dismiss petitions. The rule history note states that the rule repeal was effective May 22, 2014.[8/]

50. For the 15-month period from late May 2014 through late August 2015, the Division accepted reimbursement dispute petitions and resolved the reimbursement disputes, even though a workers' compensation managed care arrangement was involved, just as it had been doing for years for reimbursement disputes involving contracts.

51. On or about August 24, 2015, the Division changed its policy on issuing determinations when a contract (including a

managed care arrangement) was alleged in the petition. In all determinations of reimbursement disputes issued after August 24, 2015, if a contract or managed care arrangement was alleged, the Division stopped making findings regarding the contracted-for reimbursement amount. Instead, the Division started reciting the fee schedule/MRA amount or applicable statutory formula amount, making no determination regarding whether the carrier properly adjusted or disallowed payment, or, if an improper adjustment or disallowance, how much the reimbursement should have been under the contract and how much the carrier was required to reimburse the provider within 30 days. The Division changed the name of the form it used from "Resolution of Reimbursement Dispute Determination" to just "Reimbursement Dispute Determination," signaling that the Division would no longer be resolving reimbursement disputes involving contracts. Instead, the following language appeared in each such determination:

> The amount listed above does not apply to any contractual arrangement. If a contractual arrangement exists between the parties, reimbursement should be made pursuant to such contractual arrangement.

52. Exhibit FS3 is an example showing a Division "determination" applying its new policy to a reimbursement dispute petition filed by an ASC member of FSASC. Part IV of the form, "Reimbursement Dispute Policies and Guidelines,"

reflects (as did prior determinations) that the reimbursement manual for ASCs, adopted by rule, "sets the policies and reimbursement amounts for medical bills." As previously noted, the reimbursement manuals set reimbursement amounts at either the MRA/statutory formula or the agreed-upon contract price, consistent with the policy in section 440.13(12)(a). Nonetheless, the Division added a note to the end of part IV:

> NOTE: This reimbursement determination is limited in scope to standards and policies set forth in chapter 440, Florida Statutes, including all applicable reimbursement schedules, practice parameters, and protocols of treatment. It does not interpret, apply or otherwise take into account any contractual arrangement between the parties governing reimbursement for services provided by health care providers, including any workers' compensation managed care arrangement under section 440.134, Florida Statutes.

Ex. FS3 at 2.

53. Accordingly, even though the determination form reflects that the ASC petitioner met its filing requirements for a reimbursement dispute over a bill for services in the amount of $5,188.00, none of which was paid according to the EOBR, and even though the carrier failed to file a response to the petition, the Division did not make a determination that the carrier improperly disallowed payment or that the petitioner had substantiated entitlement to additional reimbursement in the amount of the agreed-upon contract price, as it had in previous

determinations. Instead, the Division set forth the "correct reimbursement" amount that would apply if the MRA applied, while noting that amount would not apply if there was a contractual arrangement providing a different amount. The carrier was not ordered to remit any amount within 30 days.

B. Reimbursement Disputes Involving Issues of Compensability or Medical Necessity

54. Prior to November 2015, the Division resolved reimbursement disputes by determining the issues as framed by the carrier's actions under section 440.13(6), to disallow or adjust payment of a bill or specific line items in a bill for reasons (codes) in the EOBR, which were contested by the provider in a timely-filed petition under section 440.13(7)(a).

55. The EOBR code list contains one code (code 10) for denial of payment of an entire claim based on non-compensability of an injury or illness. One other code (code 11) is for partial denial of payment, where there is a compensable injury, but a specific line item indicates treatment unrelated to the compensable injury. Five additional codes (codes 21 through 26) apply to disallowed payments for various medical necessity reasons. Fla. Admin. Code R. 69L-7.740(13)(b).

56. Prior to November 2015, the Division resolved reimbursement disputes when the provider timely petitioned to contest the disallowance or adjustment of payment by a carrier,

as set forth in the EOBR, including when the EOBR cited compensability and/or medical necessity code(s) as the reason(s) for disallowing or adjusting payment of a provider's bill.

57. On or about November 2, 2015, the Division changed its policy and no longer addressed in its reimbursement dispute determinations whether a carrier properly or improperly disallowed or adjusted payment for reasons of medical necessity or compensability. Exhibit AH6 is an example of a Division written determination that makes no determination of whether a carrier properly or improperly disallowed payment of a line item based on a medical necessity issue (EOBR Code 24). Instead, the "determination" included this note:

> Note: The Department will not address any disallowance or adjustment of payment where the basis for the disallowance or adjustment or payment by the carrier involves denial of compensability of the claim or assertion that the specific services provided are not medically necessary.

Ex. AH6 at 2. This note has been included in all determinations issued after November 2015, where payment was disallowed or adjusted based on medical necessity or compensability.

Rulemaking Process

58. The Division began rule development to incorporate its policy changes in amendments to chapter 69L-31. A Notice of Development of Proposed Rules was published on December 16, 2015. The notice set forth the preliminary text of proposed

amendments, including new proposed rule 69L-31.016, entitled "Reimbursement Disputes Involving a Contract or Workers' Compensation Managed Care Arrangement." The notice stated that the purpose and effect of proposed rule 69L-31.016 was "to limit the scope of dispute resolutions to compliance with standards under Chapter 440, F.S. and exclude issues of contract interpretation." The exclusion of disallowed or adjusted payments based on issues of compensability and medical necessity, not mentioned in the statement of purpose and effect, was initially put in rule 69L-31.005, in a paragraph stating that the Department will only address specific EOBR line items where the carrier adjusted or disallowed payment and are disputed by the provider, but then stating that the Department will not address specific EOBR adjustment or disallowance items involving compensability or medical necessity, even if disputed. A rule development workshop was held on January 12, 2016.

59. The Department published a second Notice of Development of Proposed Rules, revising the proposed changes to chapter 69L-31, including both the contract/managed care exclusion and the compensability/medical necessity exclusion. On June 10, 2016, the Division held a second rule development workshop addressing the proposed rule revisions.

60. On December 7, 2016, the Division published a Notice of Proposed Rules, formally initiating rulemaking to revise chapter 69L-31. The notice set forth a revised proposed rule 69L-31.016. Its new title was "Reimbursement Disputes Involving a Contract or Workers' Compensation Managed Care Arrangement or Involving Compensability or Medical Necessity," joining in one rule all of the new exceptions, for which the Division would not be making determinations of whether carriers properly or improperly adjusted or disallowed payments. As proposed, the rule provided:

> (1) When either the health care provider or carrier asserts that a contract between them establishes the amount of reimbursement to the health care provider, or where the carrier provided health care services to the injured worker through a workers' compensation managed care arrangement pursuant to Section 440.134, F.S., the Department will not issue a finding that there has been any improper disallowance or adjustment. Instead, the determination will only indicate the reimbursement amount for the treatment established by the appropriate reimbursement schedules, practice parameters, and protocols of treatment under Chapter 440, F.S., to assist the health care provider and carrier in their independent application of the provisions of the contract or workers' compensation managed care arrangement to resolve the dispute.
>
> (2) When the carrier asserts the treatment is not compensable or medically necessary and as a result does not reimburse, the Department will not issue a finding that there has been any improper disallowance or adjustment. Instead, the determination will

> only indicate the reimbursement amount for the treatment established by the appropriate reimbursement schedules, practice parameters, and protocols of treatment under Chapter 440, F.S., should compensability or medical necessity be later established.

61. The stated purpose of proposed rule 69L-31.016 was to specify "that the scope of Department determinations involving reimbursement disputes is limited to findings relating to reimbursement schedules, practice parameters, and protocols of treatment, and [to clarify] that the Department will issue no findings regarding an improper disallowance or adjustment in reimbursement involving managed care contracts or when the carrier asserts that medical treatment was either not compensable or not medically necessary[.]" Jt. Ex. 3.

62. As published in December 2016, proposed rule 69L-31.016 cited sections 440.13(7)(e) and 440.591 as the "rulemaking authority," and sections 440.13(7) and (12)(a) and 440.134(15) as the "laws implemented."

63. The Division's notice stated that, based on its determinations as to adverse impact and regulatory costs: "A SERC has not been prepared by the Agency." Jt. Ex. 3.

64. By letter dated December 28, 2016, Parallon proposed a LCRA to the proposed rule 69L-31.016(1) (and to other proposed rules not at issue in this proceeding). The LCRA explained that Parallon was already experiencing increased costs because of the

Division's unadopted policy, and Parallon proposed that the most appropriate lower cost alternative to accomplish the statutory objectives was not to adopt proposed rule 69L-31.016(1).

65. On January 5, 2017, the Division held a public hearing on the proposed rules. Petitioners (through counsel) offered comments in opposition to the proposed rules. Parallon's counsel also submitted the LCRA letter into the record.

66. On May 2, 2017, the Division published a Notice of Correction. The notice stated that, contrary to the statement in the Notice of Proposed Rules, SERCs had been prepared for the proposed rules, and that the SERC for proposed rule 69L-31.016 now had been revised to address the LCRA.

67. The impression given by the various documents identified as a SERC or revised SERC, half of which are entitled "Department of Financial Services Analysis to Determine if a [SERC] is Required," all of which are similar or identical in content, and none of which bear a date, is that, prior to the LCRA, Respondent did not prepare a SERC for proposed rule 69L-31.016; it prepared a document by which it determined that no SERC was required. After the LCRA was filed, Respondent added a reference to the LCRA, but otherwise did not change the content of its non-SERC.

68. In the Notice of Correction, the Division stated: "The [SERC] for each of the above-referenced proposed rules is

available by accessing the Department's website at http://www.myfloridacfo.com/Division/WC/noticesRules.htm."

69. The document titled "Department of Financial Services Analysis to Determine if Statement of Estimated Regulatory Costs Is Required," referred to by the Division as the SERC, was not available on the DFS website on May 2, 2017, as the Notice of Correction indicated. Instead, it was available at the referenced website location on or after May 3, 2017. Upon request by counsel for Parallon on May 3, 2017, the document referred to as a SERC was also provided to Parallon.

70. Mr. Sabolic testified that the document referred to as the SERC was actually available at the Division on May 2, 2017, and would have been made available to someone if it was requested on that day. However, the noticed means by which the document would be "made available" was at a specific website location that was not functional until May 3, 2017.

71. The so-called SERC document for proposed rule 69L-31.016 suffers from several obvious deficiencies. As to the Division's "economic analysis," the document states: "N/A." That is because the Division did no economic analysis.[9/] In response to two separate prompts, for the Division to set forth a "good faith estimate of the number of individuals and entities likely to be required to comply with the rule," and separately, to give a "general description of the types of

individuals likely to be affected by the rule," the Division gave the identical response: "This Rule changes how the Medical Services Section review Petitions for Resolution of Reimbursement Disputes. Only the Medical Services Section will be required to comply." In addition, the document indicates (with no explanation or analysis) that there will be no transactional costs to persons required to comply with the new rule, and no adverse impact at all on small businesses.

72. In contrast to the so-called SERC document indicating that only the medical services section will be required to comply with, or be impacted by, the proposed rule, in the Division's 2013 legislative proposal seeking to remove its statutory authority to determine reimbursement disputes involving contracts, the Division was able to identify persons who would be affected by the proposal, acknowledging as follows: "Workers' compensation carriers, including self-insurers (DFS Div. of Risk Mgmt), third party administrators, and health care providers, including facilities, are affected." And, of course, the Division was well aware by May 2017 of the variety of providers and carriers expressing their interests and concerns during the rule development that had been ongoing for 17 months by then. To say that the Division gave the SERC task short shrift would be generous. The Division did not take this task seriously.

73. The so-called SERC document also identified the Parallon LCRA. In response to the requirement to describe the LCRA and provide either a statement adopting it or a statement "of the reasons for rejecting the alternative in favor of the proposed rule," the Division stated:

> Parallon's lower cost regulatory alternative consisted of a cost-based argument against the adoption of the proposed rule on the basis that the existing rule provides a lower cost alternative. The Division rejected the regulatory alternative and intends to move forward with adoption on the proposed rule, but will revise the proposed rule to read as follows[.]

Jt. Ex. 12, at bates-stamp p. 48. The reference to a revision to the proposed rule does not belong in the statement of reasons for rejecting the LCRA. Its placement there was misleading, as if the revision to the proposed rule helped to explain why the Division rejected the LCRA. But no revision was made to the rule to which the LCRA was directed--proposed rule 69L-31.016(1). The revision was to proposed rule 69L-31.016(2), not addressed by the LCRA.

74. At hearing, Mr. Sabolic attempted to provide the statement of reasons for rejecting the LCRA, missing in the so-called SERC document. He said that the cost-based argument was considered speculative and lacked data (but that explanation was not in the so-called SERC document). Although he thought that the SERC document stated that the LCRA was rejected

because it was based on a "faulty" cost-based argument, the word "faulty" was not in the SERC. On its face, the SERC offers no reason why the "cost-based argument" was rejected—just that it was rejected.

75. The amendment to proposed rule 69L-31.016(2) mentioned in the SERC document was also published on May 2, 2017, in a Notice of Change. The change was shown as follows:

> When the carrier asserts the treatment is not compensable or medically necessary and as a result does not reimburse, ~~the Department will not issue a finding that there has been any improper disallowance or adjustment. Instead,~~ the determination will only address line items not related to ~~indicate the reimbursement amount for the treatment established by the appropriate reimbursement schedules, practice parameters, and protocols of treatment under Chapter 440, F.S., should~~ compensability or medical necessity ~~be later established~~. If the petitioner has submitted documentation demonstrating the carrier authorized the treatment, the Department will issue a finding of improper disallowance or adjustment.

76. The Notice of Change did not change either of the other challenged provisions—proposed rule 69L-31.016(1) and the proposed deletion of rule 69L-31.005(2)(d).

77. The Notice of Change deleted the prior citation to section 440.13(12)(a) as one of the laws implemented by proposed rule 69L-31.016, leaving only sections 440.13(7) and 440.134(15) as the laws implemented.

Division's Justifications for the Challenged Proposed Rules

78. Mr. Sabolic was Respondent's hearing representative and sole witness to explain and support the challenged rules.

79. Mr. Sabolic testified that when a contract dictates the reimbursement amount, the Division does not believe it has statutory authority to interpret or enforce contract terms. Yet he acknowledged that the Division's reimbursement determinations were required to be based on policies set forth in chapter 440, and that the Division was required to apply its reimbursement manuals that are promulgated as rules. Both chapter 440 and the reimbursement manuals expressly require reimbursement at the agreed-upon contract price, as detailed above. The Division recognized this for a decade, during which it applied chapter 440 and its reimbursement manuals to determine the agreed-upon contract price, resolve reimbursement disputes, and order carriers to pay the amount required by their contracts.

80. The Division's rationale stands in stark contrast to the Division's 2013 request for a legislative amendment to remove its statutory authority to determine reimbursement disputes when reimbursement is dictated by contracts. The Division's request constitutes an admission that it believes it has the statutory authority it now says it lacks.

81. Apart from statutory authority, Mr. Sabolic indicated that in the decade during which the Division did resolve

reimbursement disputes involving contracts, it was sometimes difficult to determine whether there was a contract in effect between the parties. There was a variety of contracts, and sometimes they were complex.

82. With regard to managed care arrangements, Mr. Sabolic said that, similar to contracts, the Division does not think it has the power to interpret or enforce managed care arrangements, because that power lies within AHCA under section 440.134. He said that section 440.134(15) was cited as a law implemented by proposed rule 69L-31.016 because the statute addresses grievance or complaint procedures under a managed care arrangement.

83. Intervenors Summit Companies attempted to prove that providers are required to resolve reimbursement disputes involving workers' compensation managed care arrangements by using the grievance process described in section 440.134(15). The evidence failed to support that contention. The evidence showed that the grievance form used by the Summit Companies' managed care arrangement, approved by AHCA, describes the grievance process as encompassing "dissatisfaction with medical care issues provided by or on behalf of a workers' compensation managed care arrangement." Tr. 323. As confirmed by the definitions of "complaint" and "grievance" in the workers' compensation managed care law, the grievance process is used to resolve an injured worker's dissatisfaction with an insurer's

managed care arrangement, including a refusal to provide medical care or the care provided. See § 440.134(1)(b) and (d), Fla. Stat. Although under AHCA's rules and the Summit Companies' form, providers may initiate the grievance process, they would be doing so essentially on behalf of the injured worker or in tandem with the injured worker to resolve the injured worker's dissatisfaction with medical care issues. When the issue is the insurer's refusal to provide medical care, the grievance process is an administrative remedy for the injured worker that has to be exhausted before an injured worker can file a petition for benefits pursuant to section 440.192. Not surprisingly, providers have not attempted to file grievances to raise reimbursement disputes with insurers, as nothing in section 440.134(15), the rules, or the Summit Companies' approved form contemplate use of the process for that purpose, much less mandate it.

84. Strangely, Mr. Sabolic attempted to justify the proposed rule's carve-outs from the reimbursement dispute process by reference to section 440.13(11)(c), which gives the Department "exclusive jurisdiction to decide any matters concerning reimbursement[.]" As he put it:

> I think that the statute indicates we can decide any matter relating to reimbursement under 440.13(11)(c), and that's how we're deciding to deal with those situations when a managed care arrangement or a contract is

> involved. That's our decision. Our decision is that that determination's going to reflect the amount that is in the applicable reimbursement manual for that service date.

Tr. 232. It must be noted that section 440.13(11)(c) was not cited as one of the laws implemented by the proposed rules, even if the premise could be accepted that a grant of exclusive jurisdiction to decide any matter concerning reimbursement includes authority to decide never to decide certain matters concerning reimbursement.

85. Mr. Sabolic admitted that under proposed rule 69L-31.016(1), the Division does not and will not issue a written determination of whether the carrier properly adjusted or disallowed payment when a contract or managed care arrangement is involved.

86. Mr. Sabolic testified that the proposed deletion of rule 69L-31.005(2)(d) (requiring a copy of the contract or managed care arrangement addressing reimbursement) is tied to proposed rule 69L-31.016(1) that gets the Division out of the business of looking at contracts. The Division will not require any proof that a contract or managed care arrangement governs reimbursement so as to trigger the no-decision decision. Instead, if either a provider indicates in its petition or a carrier indicates in its response that reimbursement is pursuant to a contract or managed care arrangement, that ends the

inquiry, and the Division will not determine whether the carrier properly adjusted or disallowed payment. Mr. Sabolic said that he was not concerned with the potential for abuse, because in the decade when the Division was in the business of interpreting and applying reimbursement provisions in contracts, it was very rare that the parties disagreed on whether a contract was in effect between them that governed reimbursement.

87. Mr. Sabolic offered no justification for carving out from reimbursement disputes carrier adjustments or disallowances of payment based on compensability or medical necessity issues. He just reported the Division's decision that if a carrier disallows or adjusts payment for line items on bills and cites reasons (EOBR codes) involving compensability or medical necessity, "we will indicate that we're not going to issue a determination on those line items and [we will] only issue a determination on those line items which don't reflect the carrier's disallowance related to compensability or medical necessity." But if the petitioner gives "proof that the carrier authorized treatment," the Division "will proceed with rendering a determination related to those line items." Tr. 197.

88. The Division's determinations under proposed rules 69L-31.016(1) (when a contract or managed care arrangement is alleged) and 69L-31.016(2) (when payment is disallowed or adjusted for compensability or medical necessity reasons) are

characterized by the Division as "neutral determinations" in which there is no winner and no loser. A more fitting characterization is "non-determination."

CONCLUSIONS OF LAW

89. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties to this action, pursuant to sections 120.56, 120.569, and 120.57(1).

90. Section 120.56(1)(a) provides that any person substantially affected by a proposed rule may seek an administrative determination of the invalidity of the rule on the ground that the rule is an invalid exercise of delegated legislative authority. Pursuant to section 120.56(2)(a), Petitioners have the burden to prove their standing, and if they meet their burden, then Respondent has the burden to prove that the challenged proposed rules are not invalid exercises of delegated legislative authority. The standard of proof is by a preponderance of the evidence. § 120.56(2)(a), Fla. Stat. Proposed rules are not presumed to be valid or invalid. § 120.56(2)(c), Fla. Stat.

Standing

91. To establish standing, Petitioners must prove they would be substantially affected by the proposed rules they seek to challenge. To meet this test, one must demonstrate that a proposed rule will result in a real and immediate injury in

fact, and that the alleged interest is within the zone of interest to be protected or regulated. Jacoby v. Fla. Bd. of Med., 917 So. 2d 358, 360 (Fla. 1st DCA 2005); see also Fla. Bd. of Med. v. Fla. Acad. of Cosmetic Surgery, 808 So. 2d 243, 250 (Fla. 1st DCA 2002), superseded on other grounds, Dep't of Health v. Merritt, 919 So. 2d 561 (Fla. 1st DCA 2006).

92. The court in Jacoby found that the injury-in-fact prong was satisfied there because "[a]ppellant is subject to the licensing rules and policies of the state as a potential applicant, and he has already suffered an immediate impact because of those rules and policies." Jacoby, 917 So. 2d at 360. The court confirmed its prior holding that "if an individual is affected by licensing rules because that individual works in the area that is regulated, the 'substantially affected' requirement is satisfied." Id. (citing Prof'l Firefighters of Fla., Inc. v. Dep't of Health & Rehab. Servs., 396 So. 2d 1194, 1195 (Fla. 1st DCA 1981)).

93. As an association, FSASC must meet the three-prong test in Florida Home Builders Association v. Department of Labor and Employment Security, 412 So. 2d 351, 353-354 (Fla. 1982). FSASC must prove: a substantial number of its members, though not necessarily a majority, would be substantially affected by the challenged rules; the subject of the rules is within FSASC's

general scope of interest and activity; and the relief sought is appropriate for FSASC to seek on behalf of its members.

94. As found above, Petitioners (or, in the case of FSASC, Petitioner's members) are participants in the reimbursement dispute process mandated by the workers' compensation law and are regulated by the rules in chapter 69L-31 (which will include the challenged proposed rules, if adopted). Since Respondent has been applying the policies in the proposed rules for roughly two years, the policies have already been applied to Petitioners to limit the scope of the reimbursement dispute process that had previously been available to them.

95. Petitioners challenging proposed rule 69L-31.016(1) have already been directly and immediately harmed by the policies Respondent seek to codify as rules, in that Respondent has already issued so-called determinations that do not determine whether carriers have improperly adjusted or disallowed payment, and that do not order the carriers to promptly pay. Before Respondent applied its unadopted policies, when reimbursement was dictated by a contract or managed care arrangement, Respondent would determine whether the carrier improperly adjusted or disallowed payment of a provider's bill, Respondent would determine the proper reimbursement amount pursuant to the contract or managed care arrangement, and

Respondent would order the carrier to promptly pay that amount. Respondent would resolve the reimbursement dispute.

96. Similarly, Petitioner AHCS, challenging proposed rule 69L-31.016(2), has already been directly and immediately harmed by the policy Respondent seeks to codify as a rule to not determine whether carriers properly adjusted or disallowed payment for line items on a provider's bill for reasons related to compensability or medical necessity. Previously, the Division would make these determinations and resolve these disputes. AHCS has already received determinations from Respondent that refuse to address line items adjusted or disallowed based on compensability or medical necessity EOBR codes. The Division is not resolving these reimbursement disputes. The proposed rule limitation has already been applied to limit the reimbursement dispute process available to AHCS.

97. Respondent acknowledges that Petitioners have protected interests at stake here that are within the zone of interest sought to be protected by the reimbursement dispute process. But Respondent disputes the directness or immediacy of Petitioners' injuries (while agreeing, incongruously, that Intervenors are directly and immediately impacted by the proposed rules, as their apparent beneficiaries). Respondent offers only a specious argument that Petitioners are required to quantify with precision the amount of lost income by reason of

application of the unadopted policies in order to prove they will be injured in fact by the adoption of the proposed rules. With regard to the testimony Petitioners offered as to the harm that has accrued already, Respondent attempted to characterize it as speculative because the witnesses did not produce comprehensive specific data showing their total dollar impacts.

98. Respondent's position hinges on a plain misreading of Office of Insurance Regulation v. Secure Enterprises, LLC, 124 So. 3d 332 (Fla. 1st DCA 2013), that disregards the following:

> [T]he manufacturer in this case is claiming economic harm based upon the absence of an insurance credit that Florida homeowners have never been provided. Had this been a situation where OIR eliminated an existing insurance credit for garage doors, Appellee's injury in fact argument would be much stronger. However, as it stands, Appellee has no protected economic right that has been impaired by the rules and form at issue. *See State, Bd. of Optometry [v. Florida Society of Ophthalmology*, 538 So. 2d 878, 881 (Fla. 1st DCA 1988)].
>
> * * *
>
> With respect to the ALJ's reliance upon *Televisual Communications, Inc. [v. State, Department of Labor and Employment Security*, 667 So. 2d 372 (Fla. 1st DCA 1995)], he reasoned that in that case, the appellant's president's testimony of a potential doubling in sales, "evidently without more," was held not to be speculative. The ALJ also reasoned that that case, along with the other cases he relied upon, illustrated the "legitimate role of reasoning and inference in determining whether a challenge has proved sufficient economic injury to prove

> injury-in-fact." Yet, not only was our holding in *Televisual Communications, Inc.* predicated on the testimony that the appellant could double its sales . . . , but it was also based on the fact that the rules at issue regulated the industry that provided the medium for education of health care providers. In other words, the proposed rule had the "collateral effect of regulating [the appellant's] industry." As OIR argues in this case, neither the statute nor the rules at issue regulate, either directly or indirectly, Appellee's industry.

124 So. 3d at 339 (emphasis added).

99. Here, unlike in Secure Enterprises, Petitioners are directly regulated by the statute, the existing rules, and the proposed rules. Moreover, here, the proposed rules seek to take away (and the unadopted policies have already taken away) from Petitioners the rights they previously exercised to use the reimbursement dispute process to resolve their reimbursement disputes involving reimbursement contracts or managed care arrangements, and to resolve disputes when carriers adjusted or disallowed payment for any EOBR code reason. These impacts alone support Petitioners' standing, under the Jacoby and Professional Firefighters line of authority. See Prescription Partners, LLC v. State, Dep't of Fin. Servs., 109 So. 3d 1218 (Fla. 1st DCA 2013) (AHCS's subsidiary has standing, based on assignment of physicians' rights to reimbursement for medication provided to injured workers, to invoke section 120.57(1) hearings to contest Division reimbursement dispute

determinations); Cole Vision Corp. v. Dep't of Bus. & Prof'l Reg., 688 So. 2d 404, 407 (Fla. 1st DCA 1997) (recognizing that a less demanding standard applies to standing in rule challenge proceedings than in substantial interest proceedings under section 120.57(1)).

100. Moreover, unlike in Secure Enterprises, Petitioners offered actual proof of actual economic harm since the Division began applying the policies it now seeks to adopt as rules.

101. Petitioners Oak Hill, Parallon, and AHCS have established their standing as substantially affected persons to challenge the proposed rules in this proceeding. Petitioner FSASC has established its standing as an association whose members are substantially affected by the challenged proposed rules. As found above, FSASC proved that it meets the other two prongs of the associational standing test.

102. Accepting Respondent's view of the exacting proof needed to prove standing would require rejection of Respondent's stipulations that Intervenors are directly, immediately, and substantially affected by the challenged proposed rules that regulate them and dictate the processes available to them in reimbursement disputes, because there were no stipulations, and no evidence at hearing, quantifying the total dollar amount of Intervenors' economic impacts. Neither Petitioners nor Intervenors would be substantially affected by the proposed

rules that directly regulate them and dictate the processes available to them in reimbursement disputes. If they do not have standing, no one would have standing. That cannot be so.

Timeliness of the AHCS Petition

103. AHCS's petition was filed 20 days after the SERC document was "prepared and made available as provided in section 120.541(1)(d)." § 120.56(2)(a), Fla. Stat. Section 120.541(1)(d) requires that the agency "shall provide notice on the agency's website that [the SERC] is available to the public." Although the Division published a notice in the Florida Administrative Register on May 2, 2017, stating that the SERC was available on its website, the website location was not functional until, at the earliest, May 3, 2017. Although the so-called SERC document was apparently prepared by May 2, 2017, the document was not "made available" pursuant to the requirements of section 120.541(1)(d) until May 3, 2017. As such, AHCS's petition was timely. The Division and Intervenors do not contend otherwise in their PFOs.

Merits of Proposed Rule Challenges

104. The determination to be made is whether Respondent met its burden to prove that the challenged proposed rules are not invalid exercises of delegated legislative authority.[10/] Section 120.52(8)(a) defines "invalid exercise of delegated legislative authority," as follows:

"Invalid exercise of delegated legislative authority" means action that goes beyond the powers, functions, and duties delegated by the Legislature. A proposed or existing rule is an invalid exercise of delegated legislative authority if any one of the following applies:

(a) The agency has materially failed to follow the applicable rulemaking procedures or requirements set forth in this chapter;

(b) The agency has exceeded its grant of rulemaking authority, citation to which is required by s. 120.54(3)(a)1.;

(c) The rule enlarges, modifies, or contravenes the specific provisions of law implemented, citation to which is required by s. 120.54(3)(a)1.;

(d) The rule is vague, fails to establish adequate standards for agency decisions, or vests unbridled discretion in the agency;

(e) The rule is arbitrary or capricious. A rule is arbitrary if it is not supported by logic or the necessary facts; a rule is capricious if it is adopted without thought or reason or is irrational; or

(f) The rule imposes regulatory costs on the regulated person, county, or city which could be reduced by the adoption of less costly alternatives that substantially accomplish the statutory objectives.

A grant of rulemaking authority is necessary but not sufficient to allow an agency to adopt a rule; a specific law to be implemented is also required. An agency may adopt only rules that implement or interpret the specific powers and duties granted by the enabling statute. No agency shall have authority to adopt a rule only because it is reasonably related to the purpose of the enabling legislation and is not arbitrary

> and capricious or is within the agency's class of powers and duties, nor shall an agency have the authority to implement statutory provisions setting forth general legislative intent or policy. Statutory language granting rulemaking authority or generally describing the powers and functions of an agency shall be construed to extend no further than implementing or interpreting the specific powers and duties conferred by the enabling statute.

A. The Contract Exclusion in Proposed Rule 69L-31.016(1)

105. Rule 69L-31.016 cites sections 440.13(7)(e) and 440.591 as the rulemaking authority and sections 440.13(7) and 440.134(15) as the specific laws implemented.

106. As described above, the reimbursement dispute process in section 440.13(7) is set up by a carrier's bill review under section 440.13(6), which culminates in an EOBR explaining the reasons and providing EOBR codes for any adjusting or disallowing payment of a provider's bill.

107. This is made clear in the Division's EOBR rule, which mandates that a carrier "shall send to the health care provider an EOBR detailing the adjudication of the submitted bill by line item, utilizing only the EOBR codes and code descriptors per line item." Fla. Admin. Code R. 69L-7.740(14). That same rule requires the following:

> An EOBR shall specifically state that the EOBR constitutes notice of disallowance or adjustment of payment within the meaning of subsection 440.13(7).

108. Section 440.13(7) provides:

UTILIZATION AND REIMBURSEMENT DISPUTES.—

(a) Any health care provider who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 45 days after receipt of notice of disallowance or adjustment of payment, petition the department to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the department results in dismissal of the petition.

(b) The carrier must submit to the department within 30 days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit such documentation to the department within 30 days constitutes a waiver of all objections to the petition.

(c) Within 120 days after receipt of all documentation, the department must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. 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 rendering its determination.

(d) If the department finds an improper disallowance or improper adjustment of payment by an insurer, the insurer shall reimburse the health care provider, facility, insurer, or employer within

> 30 days, subject to the penalties provided in this subsection.
>
> (e) The department shall adopt rules to carry out this subsection. The rules may include provisions for consolidating petitions filed by a petitioner and expanding the timetable for rendering a determination upon a consolidated petition.
>
> (f) 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 or more of the following penalties imposed by the department:
>
> 1. Repayment of the appropriate amount to the health care provider.
>
> 2. An administrative fine assessed by the department in an amount not to exceed $5,000 per instance of improperly disallowing or reducing payments.
>
> 3. Award of the health care provider's costs, including a reasonable attorney fee, for prosecuting the petition. (emphasis added).

109. The grant of rulemaking authority in section 440.13(7)(e) authorizes rules only for "carrying out" section 440.13(7), not "carving out" exceptions from the all-inclusive scope of the statutory reimbursement dispute process.

110. Section 440.591 does not provide the missing grant of rulemaking authority to carve out exceptions from the reimbursement dispute process. It is a classic general grant of rulemaking authority, providing:

> The department, the Financial Services Commission, and the agency may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon them.

111. The proposed carve-out of reimbursement disputes when reimbursement is based on a contract enlarges or modifies (by adding an exception), and certainly contravenes, the statute it purports to implement. Section 440.13(7)(a) provides, without exception, that a health provider electing to contest a carrier's notice of disallowance or adjustment of payment must petition the Department "to resolve the dispute." And section 440.13(7)(c) requires the Department to resolve the dispute: the Department "must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment." There are no exceptions for reimbursement disputes when reimbursement is dictated by contract.

112. Respondent points to the second part of section 440.13(7)(c), providing that 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 rendering its determination." This language does not support Respondent's attempt to avoid determining a reimbursement dispute when a contract dictates reimbursement. The "standards and policies

set forth in" chapter 440 include the standard for reimbursement in section 440.13(12)(a), specifying that providers are to be reimbursed at the "agreed upon contract price" instead of the MRA or statutory formula, when they have a contract with the carrier. The Division's own reimbursement manuals, which are promulgated as rules, codify this statutory reimbursement standard, providing throughout that the reimbursement amount is the contract price when there is an agreed upon contract addressing reimbursement.

113. Respondent admitted in 2013 that the reimbursement dispute statute, as it existed then and now, requires Respondent to resolve all reimbursement disputes and to interpret and apply contracts between providers and carriers when contracts govern reimbursement. Respondent believed then that it lacked the statutory authority to carve out and avoid resolving reimbursement disputes when reimbursement is established in contracts. Respondent correctly concluded then, and it is concluded now, that section 440.13(7) does not authorize Respondent to carve out and avoid resolving reimbursement disputes when reimbursement is determined by a contract.

114. Respondent and Intervenors also argue in their PFOs that Respondent could not have jurisdiction to interpret and apply contracts, because jurisdiction to interpret and apply contracts is the exclusive province of Article V courts.

115. Respondent cannot create rulemaking authority to alter a statute based on a perception that the existing statute might be unconstitutional under a separation of powers theory. Respondent's concern about whether it can constitutionally interpret and apply contracts (as it had been doing for a decade) so as to resolve reimbursement disputes that involve contracts could not justify Respondent's proposed rule.

116. Even if Respondent's new-found constitutional concern about exercising its statutory authority (not mentioned in its 2013 legislative proposal) could justify rulemaking to cure the perceived defect, the purported concern is not well-founded.

117. Respondent and Intervenors rely on cases in other than the workers' compensation context, such as Peck Plaza Condominium v. Division of Florida Land Sales and Condominiums, Department of Business Regulation, 371 So. 2d 152, 154 (Fla. 1st DCA 1979), which held that in the absence of statutory authority to interpret and enforce an ambiguous condominium contract, jurisdiction for that function was vested in Article V courts. As the court determined, "[t]here being no statutory grant of power to the Division to interpret and enforce the conflicting and ambiguous provisions of a declaration relating to the condominium, it follows, as a matter of logic, that the Division may not supplement the absence of legislative authority by a case by case attempt at rule-making control in this area. . . .

Such authority may not be brought into existence by agency ambition, insinuation, or bureaucratic osmosis." Id.

118. But here, Respondent has admitted that it has had the statutory authority all along to interpret and apply contracts when incidental and necessary to resolve reimbursement disputes. Respondent has demonstrated, through its determinations in evidence and in Final Orders following administrative hearings, that it can and will exercise that authority, applying basic contract principles to reach determinations regarding whether an agreed-upon contract exists and what the contract provides by way of reimbursement amount. See, e.g., Ex. FS1; Tech. Ins. Co. v. Dep't of Fin. Servs., Div. of Workers' Comp., Case No. 12-3834 (Fla. DOAH May 7, 2013), rejected (Fla. DFS Aug. 5, 2013). What Respondent does not have statutory authority to do, as it has also admitted, is to insinuate an exception into the statute, where none exists, to exclude reimbursement disputes involving contract-based reimbursement. That is an unlawful insinuation of authority by bureaucratic osmosis.

119. Respondent and Intervenors do not discuss the more relevant authority. Bend v. Shamrock Services, 59 So. 3d 153 (Fla. 1st DCA 2011), addresses the authority of Judges of Compensation Claims (JCCs) to interpret and apply contracts. First, the court noted that "workers' compensation is purely a creature of statute, and all rights and liabilities under the

system are established by chapter 440, Florida Statutes. A JCC has only those powers expressly provided by statute and, conversely, has no jurisdiction or authority beyond that which is specifically conferred by statute and a court may not read into chapter 440 authority not granted to the JCCs." Id. at 156 (citations omitted). The same is true for the Department.

120. The court then described the JCC's authority to interpret and apply contracts:

> A JCC has the authority to determine if a workers' compensation policy is in effect, has been properly cancelled pursuant to section 440.42(3), or whether it covers a particular individual. Accordingly, a JCC may be required to interpret contracts and examine evidence to reach such issues. A JCC might also be required to interpret a contract to determine the parties' rights and responsibilities under the Workers' Compensation Law.

Id. (citations omitted). The court considered that a JCC is not an Article V court, which was germane to limiting what the JCC could do based on the contract interpretation:

> Nevertheless, a JCC is not a court of general jurisdiction, and cannot reform contracts or effect a remedy not provided for in chapter 440. The remedy sought and obtained by Zenith here [declaring a contract void ab initio], is not available under chapter 440.

Id. (citations omitted).

121. Intervenors mention one workers' compensation decision, Total Appliance Repairs v. Nelson, 382 So. 2d 1333

(Fla. 1st DCA 1980), cited for the proposition that JCCs lack authority to adjudicate breaches of contract. But Intervenors do not mention the pertinent part of that decision:

> The authority to construe contracts has been repeatedly recognized under the statutory language vesting in the judge [of industrial claims, predecessor to JCCs] "full power and authority to hear and determine all questions in respect to [workers' compensation] claims." But that authority has in each case been exercised for the purpose of determining some claim under the statute and not for determining damages for breach of contract per se[.]

Id. at 1334 (citations omitted).

122. Here, Respondent plainly has statutory authority to resolve reimbursement disputes, and indeed, is given exclusive jurisdiction to decide any matters involving reimbursement. § 440.13(11)(c), Fla. Stat. Just as JCCs have the authority to construe contracts in carrying out their statutory authority under the workers' compensation system, so too, Respondent has the authority to construe contracts to determine reimbursement terms, in order to carry out its statutory duty to determine whether a carrier improperly adjusted or denied payment and order prompt payment when a carrier has underpaid.

123. Proposed rule 69L-31.016(1) is an invalid exercise of delegated legislative authority with regard to the carve-out for contracts, pursuant to section 120.52(8)(b) and (c).

B. The Managed Care Exclusion in Proposed Rule 69L-31.016(1)

124. In addition to the arguments for the contract exclusion, Respondent also seeks to justify the exclusion for reimbursement disputes involving managed care arrangements based on the argument that AHCA has the exclusive power over workers' compensation managed care arrangements, and that reimbursement disputes must be resolved using the grievance process authorized by section 440.134(15) (which is cited as a law implemented). That statute provides:

> (a) A workers' compensation managed care arrangement must have and use procedures for hearing complaints and resolving written grievances from injured workers and health care providers. The procedures must be aimed at mutual agreement for settlement and may include arbitration procedures. Procedures provided herein are in addition to other procedures contained in this chapter.
>
> (b) The grievance procedure must be described in writing and provided to the affected workers and health care providers.
>
> (c) At the time the workers' compensation managed care arrangement is implemented, the insurer must provide detailed information to workers and health care providers describing how a grievance may be registered with the insurer.
>
> (d) Grievances must be considered in a timely manner and must be transmitted to appropriate decisionmakers who have the authority to fully investigate the issue and take corrective action.

> (e) If a grievance is found to be valid, corrective action must be taken promptly.
>
> (f) All concerned parties must be notified of the results of a grievance.
>
> (g) The insurer must report annually, no later than March 31, to the agency regarding its grievance procedure activities for the prior calendar year. The report must be in a format prescribed by the agency and must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances. (emphasis added).

125. As shown by the emphasized language, the scope of the grievance process hinges on the statutory definitions of the two key terms, "complaint" and "grievance," in section 440.134(1):

> (b) "Complaint" means any dissatisfaction expressed by an injured worker concerning an insurer's workers' compensation managed care arrangement.
>
> * * *
>
> (d) "Grievance" means a written complaint, other than a petition for benefits, filed by the injured worker pursuant to the requirements of the managed care arrangement, expressing dissatisfaction with the insurer's workers' compensation managed care arrangement's refusal to provide medical care or the medical care provided.

126. As confirmed by the Summit Companies' witness, the grievance process is to hear and resolve an injured worker's dissatisfaction with medical care issues. Though providers may initiate the process, they would be doing so on behalf of or in

tandem with an injured worker to raise an issue of the injured worker's dissatisfaction with a medical care issue.

127. No statutory grant of rulemaking authority supports Respondent's attempt to carve out and exclude from the all-encompassing reimbursement dispute process in section 440.13(7) those reimbursement disputes involving workers' compensation managed care arrangements.

128. Section 440.134(15) confers no duties or powers on Respondent that would support its attempted exercise of rulemaking to implement that statute.

129. Respondent's argument that section 440.134(15) encompasses reimbursement disputes between providers and insurers under managed care arrangements is unsupported by the statute. To the contrary, carrier-provider reimbursement disputes are the sole province of section 440.13(7). In a subsection entitled "Investigation; Monitoring; Jurisdiction," jurisdiction is addressed in paragraph (c), which confers on the Department "exclusive jurisdiction to decide any matters concerning reimbursement[.]" § 440.13(11)(c), Fla. Stat.

130. Proposed rule 69L-31.016(1) is an invalid exercise of delegated legislative authority with regard to the managed care arrangement carve-out, pursuant to section 120.52(8)(b) and (c).

C. Proposed Rule 69L-31.016(2) (Compensability/Medical Necessity Exclusion)

131. The same reasons for determining that the contract exclusion is an invalid exercise of delegated legislative authority under section 120.52(8)(b) and (c) apply to the proposed rule carving out compensability and medical necessity from the scope of issues that will be determined by the Department in reimbursement disputes. There is no specific grant of rulemaking authority to support carving out exceptions that are nowhere in section 440.13(7).

132. Respondent failed to explain the logic and reasoning behind its proposed rule. Under the Department's rule 69L-7.740(14), the carrier's "adjudication" of a provider's bill must be explained in the EOBR by reference to EOBR codes. The EOBR is required to expressly inform providers that it serves as the notice of disallowance or adjustment for purposes of triggering the provider's right to contest the carrier's adjudication, pursuant to section 440.13(7)(a). Nothing in the statute suggests that certain EOBR codes cannot be contested. Instead, the statute is clear that if a provider wants to contest any adjustment or disallowance of payment set forth in the EOBR, the provider "must" petition the Department "to resolve the dispute." Equally clear in section 440.13(7)(c),

the Department "must" issue a written determination "of whether the carrier properly adjusted or disallowed payment."

133. Respondent and Intervenors argue in their PFOs that the reason for this proposed rule is that the Department would be encroaching on the subject matter jurisdiction of JCCs by determining matters of compensability. In this regard, the issue they raise is a red herring.

134. As explained in Hialeah Hospital v. Department of Financial Services, Division of Workers' Compensation, Case No. 12-2583 (Fla. DOAH Feb. 25, 2013; Fla. DFS Apr. 14 2013), the line of demarcation is between a complete denial of payment by a carrier because an injury or illness has not been determined to be compensable, and carrier disallowance or adjustment of payment. Reimbursement disputes pursuant to section 440.13(7) are expressly limited to disputes regarding carrier disallowance or adjustment of payment.

135. Section 440.13(1)(a) defines "compensable" as "a determination by a carrier or a judge of compensation claims that a condition suffered by an employee results from an injury arising out of and in the course of employment." When there has been no determination by a JCC that the injury is compensable under workers' compensation, a carrier's denial of payment for this reason cannot be contested in a reimbursement dispute.

136. Rule 69L-7.710(1) further illuminates on this line of demarcation, with the following definitions:

> (b) "Adjust" or "Adjusted" means payment is made with modification to the information provided on the bill.
>
> * * *
>
> (q) "Deny" or "Denied" means payment is not made because the service rendered is for treatment of a non-compensable injury or illness.
>
> * * *
>
> (s) "Disallow" or "Disallowed" means payment for a compensable injury or illness is not made because the service rendered has not been substantiated for reasons of medical necessity, insufficient documentation, lack of authorization or billing error.

137. An EOBR explains why a carrier has determined to deny, disallow, or adjust payment. But only the disallowance or adjustment of payment may be contested by petition for resolution of a reimbursement dispute, as determined by the Division's Final Order in Hialeah Hospital.

138. This distinction puts in proper perspective the various appellate decisions holding that JCCs are without jurisdiction to resolve reimbursement disputes that fall within Respondent's exclusive authority under section 440.13(7), with other decisions holding that Respondent lacks subject matter jurisdiction in a reimbursement dispute to make the initial

determination of whether an injury is compensable. Compare Bryan LGH Med. Ctr. v. Fla. Beauty Flora, Inc., 36 So. 3d 795 (Fla. 1st DCA 2010); Avalon Ctr. v. Hardaway, 967 So. 2d 268, 271 (Fla. 1st DCA 2007); Furtick v. William Shults Contractor, 664 So. 2d 288, 290 (Fla. 1st DCA 1995); and Carswell v. Broderick Constr., 583 So. 2d 803 (Fla. 1st DCA 1991) (JCC lacks jurisdiction over provider-carrier reimbursement disputes actionable under section 440.13(7)(a)), with Flagler Hosp. v. Ass'n Ins. Co., 133 So. 3d 644 (Fla. 1st DCA 2014) (Department lacks subject matter jurisdiction over a claim for reimbursement of medical bills until initial compensability is established); Amerisure Ins. Co.-Fla. v. Martin Mem'l Med. Ctr., 67 So. 3d 353 (Fla. 1st DCA 2011) (Department lacks jurisdiction over provider's claim for medical benefits where payment was denied because patient's heart condition was not compensable).

139. The question of overall non-compensability of an injury is not the issue addressed by the proposed rule. The Department has not fashioned a proposed rule that is limited to carrier denials of payment because there has not been a determination yet that injury is compensable under the workers' compensation system. Instead, the Department proposes to eliminate certain issues from its reimbursement dispute determination in a nuanced line-item-by-line-item review, where payment for a particular type of treatment might be disallowed

(i.e., "partially denied") as not related to the compensable injury (EOBR Code 11); or a line item might be disallowed for one of five different medical necessity reasons. No cogent explanation was provided why the Department must not continue to resolve these disputes as part of the reimbursement dispute process, as routinely done by the Department [and AHCA before it] prior to November 2015. See, e.g., Ex. AH5 (Division resolution of reimbursement dispute over disallowed payment based on EOBR Code 25, medical necessity); CNA Ins. Cos. v. Ag. for Health Care Admin., Case No. 01-4147 (Fla. DOAH Aug. 26, 2002; Fla. AHCA Feb. 10, 2003).

140. Respondent has no statutory authority to carve out any payment disallowances or adjustments from the reimbursement dispute process, including those based on "medical necessity" reasons. "Medical necessity" is an issue addressed by the standards of care in section 440.13(15), which Mr. Sabolic confirmed were the "protocols of treatment" that are to guide the Department in making its determination resolving a reimbursement dispute. Bill disputes predicated on "the reasonableness and necessity of services provided by health care providers" are within Respondent's jurisdiction, and not the JCC's jurisdiction. Carswell, 583 So. 2d at 803-804.

141. Proposed rule 69L-31.016(2) is an invalid exercise of delegated legislative authority based on section 120.52(8)(b)

and (c). In addition, Respondent did not prove the validity of the proposed rule under the standard set forth in section 120.52(8)(e). The proposed rule seems clear enough; it just does not seem to make any sense, and the Department chose not to offer any explanation of the logic or reasoning that it believes support the proposed carve-out for all line-item issues citing any compensability or medical necessity reasons to disallow or adjust payment.

D. Rulemaking Procedures Regarding SERC and LCRA

142. Pursuant to section 120.541(1)(b), an agency is required to prepare a SERC if the proposed rule will have an adverse impact on small businesses or is likely to directly or indirectly increase regulatory costs to a certain level.

143. Respondent's Notice of Proposed Rules stated, in December 2016, that no SERC was prepared because Respondent determined there would be no such impacts.

144. Section 120.541(1)(a) provides that if a good faith LCRA is submitted after the notice of proposed rulemaking, then the agency must prepare a SERC or revise a prior SERC to address the LCRA.

145. The Department claims that it prepared a SERC for proposed rule 69L-31.016, and that in doing so, it considered all of the statutory criteria in section 120.541(2).

146. Pursuant to section 120.541(2), a statement of estimated regulatory costs shall include:

(a) An economic analysis showing whether the rule directly or indirectly:

1. Is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;

2. Is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or

3. Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

(b) A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule.

(c) A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues.

(d) A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including local government entities, required to comply with

> the requirements of the rule. As used in this section, "transactional costs" are direct costs that are readily ascertainable based upon standard business practices, and include filing fees, the cost of obtaining a license, the cost of equipment required to be installed or used or procedures required to be employed in complying with the rule, additional operating costs incurred, the cost of monitoring and reporting, and any other costs necessary to comply with the rule.
>
> (e) An analysis of the impact on small businesses as defined by s. 288.703, and an analysis of the impact on small counties and small cities as defined in s. 120.52. The impact analysis for small businesses must include the basis for the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses.
>
> (f) Any additional information that the agency determines may be useful.
>
> (g) In the statement or revised statement, whichever applies, a description of any regulatory alternatives submitted under paragraph (1)(a) and a statement adopting the alternative or a statement of the reasons for rejecting the alternative in favor of the proposed rule. (emphasis added).

147. The document offered as a SERC does not demonstrate even a half-hearted attempt to meet the requirements for a SERC. The document does not even pass muster as an analysis to determine whether a SERC is required (as the so-called SERC document is actually titled). There is no analysis, no discussion of the information relied on to determine there would be no impacts, and no good faith estimate of the number of

persons and entities who will be required to comply with the proposed rules. There is no description at all of the types of persons likely affected by the proposed rule. If it is not a SERC (as the undersigned believes was the case as of the Notice of Proposed Rules), the Department was required to provide sufficient information to justify why no SERC was necessary, not simply check boxes, and offer stock inappropriate answers. See Fla. Med. Ass'n, Inc. v. Dep't of Health, Bd. of Nursing, Case No. 12-1545RP, FO at 63-67 (Fla. DOAH Nov. 2, 2012), aff'd per curiam, 132 So. 3d 225 (Fla. 1st DCA 2014).[11/] And, of course, if it was not a SERC to begin with, it could not be converted to a SERC by referring to it as a SERC.

148. The only change made to the so-called revised SERC for proposed rule 69L-31.016 was the addition of a reference to Parallon's LCRA. This addition, designed to respond to the LCRA, similarly fails to reflect any serious effort to respond as required by the statute by providing a statement of the reasons for rejecting the LCRA. The SERC document recognizes that the LCRA presented a cost-based argument to not adopt the proposed rule, as the lower cost alternative. That is, after all, what a lower cost alternative is supposed be. Beyond that description, the SERC document states essentially that the LCRA is rejected, because it is rejected. The document is devoid of actual reasons for rejecting the LCRA. The Division's attempt

to cure the SERC document's deficiencies by offering reasons at hearing, which were not stated in the SERC document, does not bring the SERC document into compliance. The statute requires that the SERC or revised SERC must state the reasons for rejecting the LCRA.

149. The Division materially failed to follow the required rulemaking procedures in connection with the SERC requirements and the requirement to respond to a LCRA by providing a statement of reasons for rejecting the LCRA. With regard to proposed rule 69L-31.016(1), the failure to respond to the LCRA as required by section 120.541(1)(a) constitutes a material failure to follow required procedures. See § 120.541(1)(e), Fla. Stat. With regard to proposed rule 69L-31.016(2), the Division's failure to follow the applicable rulemaking requirements related to preparing a SERC are presumed material. § 120.56(1)(c), Fla. Stat. Respondent has not rebutted that presumption by proving that it actually undertook an economic analysis and fully considered each of the factors required for a SERC. Cf. Div. of Workers' Comp., Dep't of Labor & Emp. Sec. v. McKee, 413 So. 2d 805 (Fla. 1st DCA 1982) (explaining how an agency could rebut the presumption of material error for procedural violations in connection with the statutory precursor to the SERC, an economic impact statement). Accordingly,

proposed rule 69L-31.016 is an invalid delegation of legislative authority on the additional grounds in section 120.52(8)(a).[12/]

E. Proposed Deletion of Rule 69L-31.005(2)(d)

150. Based on the invalidation of proposed rule 69L-31.016(1), which was the sole reason for proposing deletion of existing rule 69L-31.005(2)(d), the proposed deletion of rule 69L-31.005(2)(d) is arbitrary and capricious. If proposed rule 69L-31.016(1) were adopted, eliminating the required proof of an asserted contract would not be arbitrary or capricious, even though there are good reasons to keep the requirement.

151. Thus, just as the proposed deletion of existing rule 69L-31.005(2)(d) was described as linked to proposed rule 69L-31.016(1), the invalidation of proposed rule 69L-31.016(1) requires the conclusion that the proposed deletion of existing rule 69L-31.005(2)(d) is an invalid exercise of delegated legislative authority under section 120.52(8)(e).

152. Petitioners have requested attorneys' fees pursuant to section 120.595. Inasmuch as this Final Order determines that the challenged proposed rules are invalid exercises of delegated legislative authority, Petitioners are entitled to be heard as to entitlement and, if entitled, as to the amount to which they are entitled under section 120.595. In addition, Petitioner FSASC has a pending motion under section 57.105, Florida Statutes, and Respondent shall file its response as

provided in the Order issued on October 23, 2017, or as otherwise agreed by the parties or ordered by the undersigned.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that proposed rule 69L-31.016 in its entirety (including both paragraphs (1) and (2)) and the proposed deletion of existing rule 69L-31.005(2)(d) are invalid exercises of delegated legislative authority.

Jurisdiction is retained for the purpose of determining reasonable attorneys' fees and costs. Any motion to determine fees and costs shall be filed within 60 days of the issuance of this Final Order.

DONE AND ORDERED this 30th day of November, 2017, in Tallahassee, Leon County, Florida.

ELIZABETH W. MCARTHUR
Administrative Law Judge
Division of Administrative Hearings
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1230 Apalachee Parkway
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of November, 2017.

ENDNOTES

[1/] The timeliness of AHCS's petition was identified as a legal issue remaining in dispute in the Joint Pre-hearing Stipulation, and the factual predicate was addressed in the record. This issue was initially raised by Respondent in a motion to dismiss that was later withdrawn without prejudice. However, Respondent appears to no longer be contending that AHCS's petition was untimely, and Intervenors have not advocated that position, as there are no proposed findings of fact or conclusions of law on the subject in their post-hearing filing. Nonetheless, the issue is addressed herein out of an abundance of caution.

[2/] References herein to Florida Statutes are to the 2017 codification, unless otherwise noted.

[3/] FSASC's petition also challenged proposed rule 69L-31.016(1) as an invalid exercise of delegated legislative authority pursuant to section 120.52(8)(e) (arbitrary and capricious), but by motion to strike filed shortly before the final hearing, FSASC sought to withdraw that argument. On the record at the outset of the final hearing, the motion to strike was treated as a motion to amend the petition, and was granted.

[4/] The tenth day after the filing of the Transcript was Friday, November 10, 2017, which was a legal holiday, followed by a weekend. The parties applied the "Computation of Time" rule, Florida Administrative Code Rule 28-106.103, and filed their PFOs 13 days after the Transcript was filed, at the end of the day on Monday, November 13, 2017. Without seeking an extension of the 40-page limit, two of the three PFOs exceeded the page limit (Respondent's PFO, at 47 pages, and Petitioners' Joint PFO, at 67 pages). Neither of the over-limit PFOs contained page numbers, making references to those filings difficult.

[5/] An EOBR is "the document used to provide notice of payment or notice of adjustment, disallowance, or denial by a claims adjuster or any entity acting on behalf of an insurer to a health care provider containing code(s) and code descriptor(s) in conformance with [rule] 69L-7.740(13)." Fla. Admin. Code R. 69L-7.710((1)(y).

[6/] According to the legislative staff analysis for House Bill 5045, which became law in 2008 (ch. 2008-133, Laws of Fla.), the Division took over the reimbursement dispute process and other workers' compensation functions from AHCA in November 2005, pursuant to an interagency agreement between the Department and

AHCA. Chapter 2008-133, Laws of Florida, formalized the transfer of these responsibilities from AHCA to the Department in the statutes. Mr. Sabolic generally described the interagency agreement, though he was uncertain as to when exactly it began.

[7/] Pursuant to section 440.13(12)(a), a three-member panel adopts schedules of MRAs for health care treatment and attendance by physicians, hospitals, ambulatory surgical centers, durable medical equipment, and more. The statute also describes a reimbursement formula for hospital outpatient care, which is 75 percent of usual and customary charges. As to the reimbursement amount to be paid to the health care provider, though, the last sentence provides: "An individual physician, hospital, [or] ambulatory surgical center . . . shall be reimbursed either the agreed-upon contract price or the [MRA] in the appropriate schedule." Similarly, section 440.13(12)(c), addressing reimbursement for prescription medication, provides: "Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount except where the employer or carrier . . . or any entity acting on behalf of the employer or carrier directly contracts with the provider seeking reimbursement for a lower amount."

[8/] Corroborating Mr. Sabolic's testimony regarding the decision to repeal the rule in light of the rule challenge, Respondent's notice of rulemaking to repeal rule 69L-31.015 explained: "The Department has determined that it lacks the required rulemaking authority . . . ." The official summary of the proposed repeal was: "Rule 69L-31.015 is being repealed, as its provisions are not in accord with the Department's rulemaking authority." See official rule file for rule 69L-31.015, available on the Florida Administrative Code and Florida Administrative Register website at https://www.flrules.org/Gateway/View_Notice.asp?ID=14381043. Mostly corroborating Mr. Sabolic's testimony (with a slight difference as to the party bringing the challenge), a search of DOAH cases reveals that DOAH Case No. 14-1078RX was the challenge to then-existing rule 69L-31.015. The petition was filed by Osceola Regional Hospital, Inc., on March 11, 2014. A joint status report filed on April 23, 2014, represented that the Division published its notice of intent to repeal the rule on March 27, 2014, and following the expiration of the time to challenge the proposed repeal, steps were being taken to complete the repeal of the rule. When the repeal had been filed for adoption, the rule challenge was dismissed.

[9/] Mr. Sabolic explained that N/A was put beside economic analysis on the SERC form because the Department relies on the National Council on Compensation Insurance (NCCI) to perform economic analyses on such matters. He claims that NCCI was asked to perform one for these proposed rules, but that NCCI declined. No non-hearsay evidence was offered to support Mr. Sabolic's claim. Regardless, it was the Department's responsibility to prepare a SERC, as it claims to have done, and the first requirement listed in the statute is an "economic analysis." § 120.541(2)(a), Fla. Stat.

[10/] Intervenors offer a proposed conclusion of law regarding deference required to the agency's interpretation of its statutes, as follows: "Unless it is 'clearly erroneous,' the agency's interpretation of the statute, as well as its view of authority under the statute and its current rules, must be upheld." Int. PFO at 20. Pursuant to one of the cited cases, Pan Am Airways, Inc. v. Florida Public Service Commission, 427 So. 2d 716, 719 (Fla. 1985), deference would be appropriate to an agency's adopted "rules which have been in effect over an extended period and to the meaning assigned to them by officials charged with their administration." However, as made clear by section 120.56(2), no deference is to be given to an agency's interpretation of its statutes in proposed rules. Instead, the proposed rules cannot be presumed valid or invalid, and it is the agency's burden to prove their validity by a preponderance of the evidence.

[11/] Among other authority, Petitioners cited Florida Waterworks Association v. Florida Public Service Commission, Case No. 96-3809RP (Fla. DOAH Mar. 2, 1998), for the findings and determination regarding an inadequate economic analysis. However, that Final Order was reversed. Fla. Pub. Serv. Comm'n v. Fla. Waterworks Ass'n, 731 So. 2d 836 (Fla. 1st DCA 1999). This precedent is not really helpful one way or the other with regard to the issues presented here. That case arose right after the SERC statute was first enacted into law, when much less was required of agencies. Most germane to that case, there was no statutory requirement for an "economic analysis," whereas an "economic analysis" now leads off the requirements imposed on agencies in section 120.541(2).

[12/] Petitioners concede in their PFO that there is no record evidence addressing comparative regulatory costs and alternative regulatory structures so as to support invalidation of proposed rule 69L-31.016 based on section 120.52(8)(f). That concession

is accepted, and the proposed rule is not determined to be invalid on that ground.

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NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing the original notice of administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy of the notice, accompanied by any filing fees prescribed by law, with the clerk of the District Court of Appeal in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.