STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS
OFFICE OF THE JUDGE OF COMPENSATION CLAIMS SARASOTA

Louis Iommelli, Claimant, vs. Tuttle Electric, and Safeco American States Insurance Company, Employer/Carrier.	))))))))	OJCC Case No.: 03-011303DBB Date of Accident: 12/30/1991

FINAL COMPENSATION ORDER

THIS CAUSE was heard before the undersigned Judge of Compensation Claims at Sarasota, Manatee County, Florida on June 23, 2009 upon the claimant's claims for continuing evaluation and treatment of employee's injury, including dates of service 10/31/2008, 11/7/2008, 11/14/2008, 11/26/2008, 12/12/2008, 12/19/2008, 12/26/2008, January-February 2009, from 10/24/2008, and from March 6, 2009 to March 20, 2009 (Dr. Hagerty, last payment was for 10/17/2008 date of service); costs and attorney's fees. Claimant also alleges estoppel and Rule 60Q-6.113(4), F.A.C. in support of the claims. The petitions for benefits were filed on November 25, 2008, November 26, 2008, January 21, 2009, January 27, 2009, April 7, 2009, and May 6, 2009. Mediation occurred on April 8, 2009, and the parties' Uniform Statewide Pretrial Stipulation was filed on that date. Keith A. Mann, Esquire, was present on behalf of the claimant. Robert J. Osburn, Jr., Esquire was present on behalf of the employer/carrier (E/C).

E/C filed Motions to Dismiss on April 8, 2009 and May 8, 2009 on the grounds that that April and May petitions seek payment of Dr. Hagerty's bills; that she is an authorized provider; that this is a billing dispute between provider and carrier; and that the undersigned lacks jurisdiction to resolve the dispute. A hearing was held on the Motions on May 13, 2009 and ruling was reserved pending the presentation of evidence at this proceeding. E/C defended on the basis that: Dr. Hagerty remains authorized to evaluate and treat claimant; JCC does not have jurisdiction, this is a billing dispute, AHCA has exclusive jurisdiction; this is a matter of

utilization review; claims are for payment of medical bills to an authorized provider, per *Avalon Center v. Hardaway* and *Orange County v. Willis* JCC does not have jurisdiction; no fees or costs due; and E/C seeks costs.

The parties entered into the following stipulations:

a. The date of accident is December 30, 1991 and Sarasota, Florida is the proper venue.

b. There was an employer/employee relationship on the date of accident, and employer had workers' compensation insurance coverage in effect.

c. E/C accepted claimant's accident and low back injury as compensable.

d. Claimant timely reported the accident and the parties received timely notice of the pretrial and final hearing.

e. This case is not governed by a managed care arrangement.

f. Teri Hagerty, D.C. is authorized for medical treatment.

g. E/C filed notices of controvert/denial/response to petition for benefit in December 2008 and February 2009.

The following documentary items were received in evidence:

Exhibit 1: Uniform Statewide Pretrial Stipulation as amended at the beginning of the final hearing.

Exhibit 2: Deposition of Teri J. Hagerty, D.C. taken on June 10, 2009.

Exhibit 3: Deposition of Heather Huddleston taken on June 18, 2009 over claimant's objection based on the parol evidence rule to her testimony explaining the contents of her letters of disallowance.

I took judicial notice of all appropriate pleadings in the court computer file, including petitions for benefits, responses to petitions, and the Final Compensation Order previously entered in this matter on October 27, 2006.

Claimant Louis Iommelli appeared and testified at the hearing. Counsel for the parties presented oral argument and submitted written Trial Memorandum/Hearing Information Sheet.

In making my findings of fact and conclusions of law in this matter, I have carefully considered and weighed all the evidence that was presented to me by deposition testimony, medical reports and other documentary items, and by live testimony presented at the hearing. I have observed the candor and demeanor of the witness who appeared live before me and I have resolved all conflicts in the testimony and evidence. I have attempted to distill the testimony and facts together with the findings and conclusions necessary to the resolution of this claim. I have not attempted to painstakingly summarize the substance of the claimant's testimony or the testimony of any deposition witness in this matter, nor have I attempted to state non-essential facts. Because I have not done so does not mean that I have failed to consider all of the evidence. Based on the evidence and applicable law, I make the following determinations of fact and conclusions of law:

1. The stipulations of the parties are approved and accepted as findings of fact.

2. Claimant, Louis Iommelli, 58 years old, was employed as an electrician with Tuttle Electric, employer herein, on the date of accident of December 30, 1991. On that date he was standing on a ladder pulling wire through a pipe when the wire caught, and he twisted his lower back. E/C accepted the accident and injury as compensable and provided medical treatment for claimant.

3. A prior merits proceeding was held in this matter related to deauthorization of Dr. Hagerty, and a Final Compensation Order was entered October 27, 2006 ordering E/C to authorize Dr. Hagerty for continuing care and treatment of claimant. By way of background, certain findings from that Order are included herein. Claimant began treating with Dr. Hagerty on January 3, 1996. She continued be authorized to treat claimant through September 10, 2004 and then received a letter from E/C stating that she was no longer authorized to be claimant's treating physician because her treatments were no longer helping. When she began treating claimant, she was authorized to give one treatment a week, and she and claimant decided the best time for treatment would be Friday after work so that he could have his treatment, have the weekend to rest, and then not have to go back to work until Monday. She used a combination of

ultrasound with high-volt electric stim, interferential stim, hot pack, and spinal manipulation.

After Dr. Hagerty was deauthorized she continued to treat claimant until carrier authorized another physician.

4. In connection with the prior claim claimant underwent an E/C independent medical examination (IME) with chiropractor Dr. Joseph J. Koshes, Jr. on January 6, 2004. Dr. Koshes' diagnosis was lumbosacral joint sprain injury. He felt that the injuries described by claimant were causally related to the work injury and that he was at maximum medical improvement (MMI). Dr. Koshes felt that future active medical care would not be indicated because the claimant was not improving with care, and he and his attending chiropractor felt he was worsening. He said that claimant would experience intermittent flare ups of pain that would be handled by supportive care on an intermittent and not active or scheduled basis. He recommended strengthening exercises using an elastic band system to stabilize the muscles of his lower back and to make use of in-office care as minimal as possible. Dr. Koshes deferred to current providers for claimant's condition and any tests administered after his IME because he had not seen claimant since then. However, he opined that it was not reasonable and medically necessary for claimant to receive active chiropractic care fifteen years after the industrial accident.

5. Claimant began treating with chiropractor Dr. Carl Grappin on December 3, 2004, and he saw him approximately 56 times through January 13, 2006. At that time Dr. Grappin received a letter from carrier indicating that claimant must contact carrier for further care and receive authorization in writing. Dr. Grappin opined that the care and treatment he provided for claimant was reasonable and medically necessary, and allowed him to keep working week after week.

Dr. Grappin's initial treatment schedule was three times a week for one week then p.r.n. Eventually claimant began having weekly treatments with Dr. Grappin, ultimately resulting in carrier's letter indicating that he must have written authorization.

6. At the prior proceeding E/C also contended that I lack jurisdiction, arguing that it was a matter of utilization review. Claimant argued that it was not utilization review, and that if it is, the 1991 version of the statute applies and E/C had not complied with the utilization review procedures of that statute. I agreed with E/C that the utilization review section of the statute is procedural, and so the 2004 version applies, citing *Protegrity Services, Inc. v. Vaccaro*, 909 So.2d 445 (Fla. 4th DCA 2005) and *State Attorney v. Johnson*, 770 So.2d 187 (Fla. 1st DCA 2000). Subsequent to this ruling, the court in the case of *The Avalon Center v. Hardaway*, 967 So.2d 268 (Fla. 1st DCA 2007) determined that regardless of the date of accident (in that case also 1991) the current workers' compensation law should be applied as the statutes involved regarding medical benefits and reimbursement disputes are procedural.

I also agreed with E/C that I have no jurisdiction over utilization review. However, I found that I do have jurisdiction to assure that claimant receives appropriate medical treatment, to authorize health care providers where there is a dispute between claimant and employer/carrier, and to resolve conflicts between health care providers regarding a claimant's medical status. *Wolk v. Jaylen Homes, Inc.*, 593 So.2d 1058 (Fla. 1st DCA 1992). It was also noted that once E/C defends by alleging that medical care is not necessary, the medical necessity of that care is placed in issue and should be resolved by the JCC. *See, Williams v. Triple J. Enterprises*, 650 So.2d 1114 (Fla. 1st DCA 1995); *Beasley v. M & E Pieco*, 678 So.2d 519 (Fla. 1st DCA 1996). In the prior proceeding E/C defended on the alternate grounds of medical necessity, and claimant sought continuing additional chiropractic care including reauthorization of Dr. Hagerty; therefore I found that I had jurisdiction. E/C was ordered to provide continuing care with Dr. Hagerty. The October 27, 2006 Final Compensation Order was not appealed.

7. Dr. Hagerty's deposition was taken in connection with the instant proceeding on June 10, 2009. She testified that she continued to treat claimant after the Final Compensation Order, beginning on November 17, 2006, and that E/C paid for the treatment from then up through October 17, 2008. She received a letter from Heather Huddleston dated November 18, 2008 giving her notice of disallowance with reasons for the disallowance, and has received

letters thereafter with much the same wording for other visits. It was Dr. Hagerty's opinion that the treatment she provided during that time is reasonable and necessary and supportive care consistent with the nature of his injury and the progressive nature of his injury. She wrote to Huddleston May 29, 2009 with her explanation.

Dr. Hagerty disagreed with Dr. Koshes' conclusion that the treatment frequency with a supportive care program would normally occur in a random pattern due to the unpredictable nature of musculoskeletal conditions, and that her care was not supportive and therefore not appropriate in its frequency.

Dr. Hagerty testified that she wrote a letter to attorney Mann dated April 6, 2009 attaching a copy of Huddleston's latest letter to her and explaining that she has not received payment since October 17, 2008 and that all other dates of service were denied. She received two payments from E/C since then for dates of service March 27, 2009 and April 10, 2009. Although she is not receiving regular payment, she has continued to see claimant since October 17, 2008 in approximately, but not exactly, the same frequency. She said she was gone for three weeks in November 2008, was closed some for the holidays, and was out some for an injury to her back, so there were circumstances where she was not available and there may have been circumstances where they tried to go a couple or three weeks between treatments.

Dr. Hagerty paid for a month's worth of YMCA gym membership for claimant in March 2009 and was also seeking reimbursement for that. She had one contact by phone with Huddleston in addition to one contact in writing May 29, 2009 with her petition. Dr. Hagerty said she was not aware at the time Huddleston's letters came that she could challenge the disallowances. She contacted claimant's attorney to ask how she would go about getting an in depth explanation of the disallowance and what her next course of action could be. Attorney Mann told her the same thing Huddleston did, that the explanation in the letters was a representation of the statutes and that she did have the right to petition Huddleston directly and could also petition the State of Florida financial services division of workers' comp, and she did that. She said she did not contact anyone prior to May 2009 because she knew claimant was

going to need to have continuing care and she did not receive a letter stating she was deauthorized; she was just receiving notices of denial of payment of certain dates of service. Therefore she thought that at least some dates of service would be reimbursed between October 28, 2008 and spring 2009. She said she was continuing to follow up with claimant, and she is aware that he is not responsible for payment of the disallowed bills.

Dr. Hagerty testified that she spent $16,000.00 in July 2008 buying the most updated and recent state of the art equipment, which is laser therapy, in an attempt to benefit the patient, improve his quality of life, and improve the quality of her treatments because of the progressive nature of his condition worsening. She noted that the majority of her practice is made up of patients who are on Medicare and in July go north for the summer, thus she purchased a piece of equipment to begin treatment on claimant that she will not recoup the cost on for another five to six months when her patient load returns. She said the laser was the only thing they had not tried for claimant that may stand in the way of him and surgery. Both she and claimant agreed that the equipment has provided some pain relief, additional range of motion increase, and reduction of muscle spasm. She said despite this, ultimately her treatments of claimant will cease and he will undergo surgery correction. Claimant has lost forty-five pounds, and Dr. Hagerty believes that by November his cholesterol, blood sugar (he has diabetes), and his general state of health will be at a positive point that would make him a great candidate for laser decompression surgery.

Dr. Hagerty said that while the frequency of claimant's visits appear to be scheduled because they most likely occur on Friday, she wanted to emphasize that she is semiretired and she usually only takes appointments on Monday, Wednesday, and Friday.

8. Heather Huddleston is carriers' adjuster on claimant's file since October 2003. Claimant objected to her testimony explaining the content of her disallowance letters based on the parol evidence rule. However, the parol evidence rule applies to contracts, and this is not a contract action nor is there any agreement by the parties to be construed. Accordingly, claimant's objection is overruled, and Huddleston's testimony is received in its entirety.

Huddleston testified that Dr. Teri Hagerty is claimant's authorized treating chiropractor and was most recently authorized on November 17, 2006. She has been seeing claimant approximately weekly. According to Huddleston, they did a bill dispute with Dr. Hagerty in October 2008 and sent her a notification that they were denying her bills. The action was based on a report done by Dr. Koshes on October 22, 2008, who indicated that claimant's treatment should be sporadic in nature, and that the treatment being provided by Dr. Hagerty was not sporadic in nature. Dr. Koshes report was based on a review of claimant's records. On November 18, 2008 they sent Dr. Hagerty a notice they were disallowing her medical bills for various dates, and since then they issued additional disallowance letters. The reasons for the disallowances were all the same and Huddleston obtained them from Rule 69L-7.602: insufficient documentation; frequency of service not supported; medical necessity diagnosis not supported the service required; medical necessity; service rendered was not therapeutically appropriate. Huddleston testified that they were denying the bills based upon the frequency of treatment and not on medical necessity. She said that she had to choose three codes for disallowing the bills, and the three she chose were the most closely associated to the frequency objections. Huddleston said she has not denied all of Dr. Hagerty's bills, and is reviewing the medical notes and referring to Dr. Koshes' recommendation of sporadic treatment. She said she paid bills on October 31, 2008, April 21, 2009, and a couple bills since then. Huddleston testified that they were waiting for Dr. Hagerty to petition for payment so that they could get with the Department of Financial Services in AHCA and determine what would be sporadic. When she did not do that, they determined that treatment is necessary, and that's not why they were denying the bills, so they determined to sporadically pay bills waiting for her to petition.

Huddleston said she has never deauthorized Dr. Hagerty since November 2006. She responded to the petitions for benefits by indicating that Dr. Hagerty remains authorized to treat. She indicated again that she is not disputing the necessity of Dr. Hagerty's care, just the frequency. She said they have received a letter from Dr. Hagerty dated May 29, 2009on June 8, 2009 stating that it's a petition. She did not submit anything to the Department of Financial

Services in response to that letter, but said she intended to when they received the appropriate requirements, as there is a particular form that is required to be filed by the petitioning party and forms to be filed by the answering party. It was her understanding that a proper petition form has been sent to Dr. Hagerty.

9. Claimant testified that he has continued to treat with Dr. Hagerty since the last hearing and that E/C has stopped paying her bills beginning November 2008. He said that Dr. Hagerty is only in the office Monday, Wednesday, and Friday, and he calls on Wednesday for a Friday appointment. He said he needs to see her once a week because calcium builds up in his body that needs to be broken down, his back gets stiff, and he has a hard time getting up. He feels pain down his legs, and takes Ibuprofen for that. He said there are times he can't see Dr. Hagerty when he calls so he makes it for the closest available day, Monday, instead of Friday. He said he calls her every time to make his appointment, and she asks if his back is hurting.

Claimant testified that he is thinking about surgery because of tightening in his back and he has talked to Dr. Hagerty about that. She is in the process of preparing him for surgery and is keeping the swelling down. She is also helping him lose weight, and he has lost forty to forty-five pounds. He said the gym is also helping and helps his cholesterol. Claimant has diabetes and he said he can do surgery if there are no steroids that would conflict, but he is putting it off because he is scared. Claimant said he needs to see Dr. Hagerty and is not seeing her just because he likes to.

Claimant said that he stopped working December 22, 2006. He said that all of the doctors he has seen have told him that he would need surgery. Claimant agreed that he has seen Dr. Hagerty regularly since the last hearing, uninterruptedly, and there has been no effect on his medical care by E/C's denial of her bills. He indicated that Dr. Hagerty paid for a month and a half of his gym membership.

10. Sections 440.13(6) and (7) govern utilization review and utilization and reimbursement disputes. Under those sections, carriers are required to review all health care providers' bills in order to identify overutilization and billing errors, and they may hire peer

review consultants or conduct IMEs. If a carrier finds that overutilization of medical services or a billing error has occurred, or if there is a violation of the practice parameters and protocols of treatment it must disallow or adjust payment for the services without order of a JCC. Health care providers who elect to contest the disallowance or adjustment must petition the Department of Financial Services to resolve the dispute.

As noted above, I agreed in the prior proceeding, and I agree again herein that I have no jurisdiction over utilization review. I would agree with claimant's assertion that Dr. Koshes did not perform a peer review, because there is no evidence that another doctor also reviewed the case, and the definition of peer review includes two doctors. I do not agree with claimant's assertion that Dr. Koshes did not perform an IME, because there is no requirement that an IME evaluation include a physical examination. Additionally, any defects in compliance with the overutilization procedure would be within the Department's jurisdiction.

Although it would seem at first blush that this merits proceeding is the same as the earlier one in that E/C is again alleging overutilization by Dr. Hagerty with frequency of treatment being one of the issues, there are important differences between the two proceedings. At the last proceeding, E/C had deauthorized Dr. Hagerty, there was a period of time that elapsed before alternate care was authorized, and claimant was seeking reauthorization of Dr. Hagerty. Further, in addition to the jurisdictional grounds, E/C specifically disputed medical necessity of care by Dr. Hagerty and listed that as a defense on the pretrial stipulations completed by the parties.

In the instant case, Dr. Hagerty has not been deauthorized, her treatment of claimant has been uninterrupted, claimant has not paid for any of her care since the last hearing, and he is not seeking any additional care that is not being provided. Medical necessity was not listed as a defense by E/C on the pretrial stipulations for this proceeding, nor has it been raised in argument. The fact that Huddleston used some codes in her disallowance letters referencing medical necessity is not dispositive. Utilization review does not permit the E/C to interject issues such as compensability, causal relationship, etc, into the utilization process, as these matters do not avoid a payment obligation for care which has been authorized. *See, Platzek v. Rock-a-Way, Inc.*, 512

So.2d 233 (Fla. 1st DCA 1987). In this case, E/C is not contesting compensability or causal relationship of claimant's care to the industrial injury, nor are they attempting to deauthorize Dr. Hagerty. In fact, Dr. Koshes found the treatment to be appropriate (although not appropriate in frequency).

Utilization review addresses the appropriateness of the level and quality of care, based on medically accepted standards. Any inquiry into medical necessity in this context is generally limited to whether the care is appropriate to the diagnosis, as within the range of reasonable practice parameters accepted by the doctor's peers. *See, Furtick v. William Shults Contractor*, 664 So.2d 288 (Fla. 1st DCA 1995). Thus, the fact that Huddleston referenced medical necessity in her disallowance letters does not automatically place the matter within the undersigned's jurisdiction, particularly as it has not been raised as a defense herein. Nor does her sporadic payment or alleged failure to respond to Dr. Hagerty's petition entitle the undersigned to take jurisdiction, because Dr. Hagerty remains authorized to treat claimant, claimant has not been billed for treatment and has not paid for treatment, and he is not seeking treatment that he is not receiving. As such, he lacks standing to obtain payment on behalf of Dr. Hagerty, and Dr. Hagerty has a remedy by petition to the Department. Claimant's allegation of estoppel should be denied, as subject matter jurisdiction cannot be conferred by estoppel. *See, FCCI Mutual Ins. Co. v. Cayce's Excavation, Inc.*, 675 So.2d 1028 (Fla. 1st DCA 1996), decision on remand at 726 So.2d 778 (Fla. 1st DCA 1998).

Based upon the foregoing, the claim for continuing evaluation and treatment of employee's injury including the dates of services referenced should be denied and E/C's Motions to Dismiss should be granted.

11. Because the benefit sought is denied, the claim for costs and attorney's fees at E/C expense should be denied. E/C's claim for costs should also be denied as claimant's date of accident pre dates the version of the statute permitting an award of costs to the E/C, and E/C has not asserted that the petitions for benefits included claims instituted or maintained without

reasonable grounds. *See, Kaloustian v. Tampa Armature Works, Inc.*, 5 So.3d 753 (Fla. 1st DCA 2009).

WHEREFORE, based upon the foregoing, it is **ORDERED AND ADJUDGED:**

A. The claims for continuing evaluation and treatment of employee's injury including dates of service 10/31/2008, 11/7/2008, 11/14/2008, 11/26/2008, 12/12/2008, 12/19/2008, 12/26/2008, January-February 2009, from 10/24/2008, and from March 6, 2009 to March 20, 2009 (Dr. Hagerty, last payment was for 10/17/2008 date of service) are denied and dismissed.

B. The claim for costs and attorney's fees at E/C expense is denied.

C. The claim for costs at claimant's expense is denied.

DONE and ORDERED in chambers in Sarasota, Florida.

Diane B. Beck
Judge of Compensation Claims
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I CERTIFY that the foregoing Final Compensation Order was entered and a copy served by U.S. mail or electronic mail on each party and counsel at the addresses below on July 16, 2009:

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