

IN THE SUPREME COURT OF FLORIDA

CASE NO.: SC08-1407

DCA Case No: 3D07-1453

HEALTH OPTIONS, INC.

Petitioner,

vs.

PALMETTO PATHOLOGY SERVICES, P.A.

d/b/a FLORIDA PATHOLOGY SERVICES,

Respondent.

**JURISDICTIONAL ANSWER BRIEF OF THE RESPONDENT
PALMETTO PATHOLOGY SERVICES, P.A.**

On Review from the District Court of Appeal
Third District

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STATEMENT OF THE CASE AND FACTS¹

Pursuant to settled law, the "conflict" required for assertion of this Court's jurisdiction under Fla. Const. art. V, §3(b)(3) must appear on the face of the decision from which review is sought, with the only relevant facts, those "within the four corners of the decision allegedly in conflict." Reaves v. State, 485 So .2d 829, 830 n.2 (Fla. 1986). Health Options, Inc. ("HOI") tacitly concedes there is no conflict here by a jurisdictional brief which adds "facts" to the district court's decision, and is devoid of supporting citations. Accordingly, this new "Statement of the Case and Facts," taken from the district court's decision, follows.

HOI is Blue Cross/Blue Shield of Florida's health maintenance organization ("HMO"). (App. 2). It provides medical services to commercial, non-Medicare subscriber members in exchange for premium payments. (App. 2). This arrangement is memorialized in a contract between members and HOI which outlines covered services and is expressly subject to "all applicable state and federal laws and regulations." (App. 2; 9, n. 6).

HOI's primary duty is to provide coverage for "medically necessary" services and supplies, i.e. those "required for the identification, treatment or management of a condition." (App. 2

¹ References to the Third District's decision are to attached Appendix.(App. 1-16). References to the Petitioner's Jurisdictional Brief appear as (J.B. p.____).

& n. 1). HOI enters into contracts with hospitals, doctors and other health care providers in many cases, negotiating rates for services rendered to its member. (App. 3). In other cases, as here, a specialist or provider may be "non-participating," with the result that the amount of reimbursement payable for services or equipment rendered to HOI member/subscribers may be in dispute. (App. 3).

Palmetto Pathology Services, P.A. ("PPS") is a group of board certified pathologists, which provides professional anatomic and clinical pathology services, including laboratory analysis to HOI's commercial non-Medicare subscriber members in two area hospitals. (App. 3). HOI and PPS had a written contract regarding the price of those services through 1999. In that year, HOI refused to continue paying for one component of services as part of a cost-cutting measure to save itself \$4.1 million dollars annually. (App. 3 & n. 2).²

This component includes nine specific, enumerated categories of activity, recognized by the American Medical Association's Current Procedural Terminology Editorial Panel as a discrete component of work done by hospital clinical pathology laboratories. (App. 3-4, n. 3). It includes quality control, record keeping, the establishment of protocols and test methodologies, supervision, the assurance of compliance with regulatory requirements, and supervision of technicians and

² At this point, PPS became a "non-participating" provider. (App. 4).

other staff. Id. HOI described this component as "non-patient specific services," or "overhead," while PPS referred to it as the "professional component of clinical pathology" or "PC-CP". The Third District used the term "disputed services" because the lawsuit turned on whether HOI was required to compensate PPS for these services. (App. 4).

PPS sought to recover payment for the disputed services from HOI directly. (App. 5). It sued as an intended third party beneficiary of HOI's commercial non-Medicare member/subscriber contracts, which incorporated Florida statutes and regulations by reference. (App. 5). HOI responded that (1) the disputed services were not compensable because they were not rendered by the pathologists to patients "face-to-face;" (2) it was "double-paying" for these services since it had already rendered "a payment" to the two area hospitals. (App. 6).

The trial court directed a verdict on liability in PPS' favor, and the case proceeded to a jury trial on damages, resulting in a substantial plaintiff's verdict. (App. 7). HOI appealed the resulting judgment on the basis that "the trial court erred in its determination that HOI was liable to PPS as a matter of law." (App. 7).

In a **unanimous** 16 page decision, the Third District Court of Appeal rejected HOI's argument. (App. 1-16). It found that PPS established its right to payment under Foundation Health v. Westside EKG Associates, 944 So. 2d 188 (Fla. 2006), Florida's

Health Maintenance Organization Act," §641.17-.3923, Fla. Stat. and applicable administrative rules, all of which govern HMOs and were incorporated into HOI's commercial non-Medicare subscriber contracts. (App. 8-9, & n. 6; 10-11).

In this regard, section §641.3154(1), Fla. Stat. (2007) provides that an HMO is liable for services rendered by a provider to an HMO member "regardless of whether a contract exists between the organization and the provider." (App. 10). Fla. Admin. Code R. 690-191.049(2) requires an HMO to "pay for medically necessary and approved physician care rendered to a non-Medicare subscriber at a contracted hospital which services are covered by the HMO subscriber contract." (App. 10).

The administrative code rule replaced a Dept. of Insurance bulletin which required HMOs to reimburse ancillary providers for covered professional services rendered **directly** to HMO member/subscribers. (App. 10-11, emphasis added). The rule, effective 1992, eliminated and thereby rejected the word "directly," requiring reimbursement of medically necessary clinical pathology services rendered to (not "rendered directly to") HMO subscriber members. (App. 10-11).

Moreover, "physician care" as defined by Florida law, is "care, provided or **supervised** by physician," including consultant and referral services. Fla. Admin. Code R. 690-191.024(13)(c). (App. 10, emphasis in original). The "disputed

services" included supervisory duties, consultants, and referrals by the pathologists. (App. 10).

Thus, HOI's commercial non-Medicare member/subscriber contracts, and incorporated Florida statutes and regulations, all **negated** HOI's claim that it was only required to pay for "hands on" patient care. (App. 9-11 & n.6).

Contrary to suggestion, (J.B., p.3) this case did not involve a "windfall." As the Third District took pains to observe, PPS was **not** paid by the hospitals, which had a contract with HOI for different services. (App. 4-5). PPS was not reimbursed by HOI for the disputed services, and PPS was statutorily prohibited from direct billing HOI's members if HOI was liable for payment. Far from "double payment," PPS received **no** payment at all, while HOI was saving \$4.1 million dollars annually. (App. 3, n.2; 5).

SUMMARY OF THE ARGUMENT

HOI's resort to facts outside the four corners of the Third District's decision constitutes tacit recognition that there is no conflict jurisdiction.

The District Court's decision in this contract case further bears no resemblance to, and is not in express, direct conflict with, the Fifth District's decision in Central States, Southeast & Southwest v. Florida Society of Pathologists, 824 So. 2d 935 (Fla. 5th DCA 2002), a tort case.

All agreed that the "disputed services" at issue here were "covered" under HOI's commercial, non-Medicare member/subscriber contracts. The Third District held that HOI had a legal obligation to pay for medical services "rendered to" its members, pursuant to its contract, the plain and unambiguous language of incorporated Florida statutes and regulations, and Foundation Health v. Westside EKG Associates, 944 So. 2d 188 (Fla. 2006).

Central States was not an HMO case, and did not deal with an HMO's legal obligation to pay for "covered" services. Central States defended a tort action armed with a federal court ruling that the medical services at issue were **not** covered under its ERISA plan.

In sum, these cases are distinguishable in controlling elements and the points of law they establish are not the same. Kyle v. Kyle, 139 So. 2d 885, 887 (Fla. 1962). Accordingly, there is no conflict jurisdiction under Florida Const. art. V, §3(b)(3).

ARGUMENT

THERE IS NO EXPRESS DIRECT CONFLICT BETWEEN THE THIRD DISTRICT'S DECISION (WHICH RESTS ON CONTRACT PRINCIPLES AND STATUTORY INTERPRETATION) AND THE FIFTH DISTRICT'S DECISION (WHICH RESTS ON TORT PRINCIPLES).

This Court's jurisdiction is circumscribed and curtailed by the Florida Constitution. Mystan Marine, Inc. v. Harrington, 339 So. 2d 200 (Fla. 1976)(noting this Court's repeated

limitations on its own jurisdiction). HOI invokes this Court's "conflict" jurisdiction, pursuant to Fla. Const. art. V, §3(b)(3).

Conflict jurisdiction requires the decision of a district court of appeal which "expressly and directly" conflicts with a decision of another district court of appeal "on the **same** question of law." Id. (emphasis added). Since conflict must appear on the face of the district court's decision, "it is pointless and misleading to include a comprehensive recitation of facts not appearing in the decision below..." Reaves v. State, 485 So. 2d 829, 830, n.3 (Fla. 1986).

The absence of conflict jurisdiction is readily apparent here from HOI's "Statement of the Case and Facts," which is **not** taken from, and contains no citations to, the Third District's decision. (J.B. pp. 1-3). Conflict jurisdiction cannot be based on "facts" which are found only in HOI's Jurisdictional Brief. Reaves v. State, 485 So. 2d at 830, n.3.

In addition, where cases are distinguishable in controlling factual elements or if the points of law settled by two cases are not the same, there is no "express, direct" conflict. Kyle v. Kyle, 139 So. 2d 885, 887 (Fla. 1962); Florida Power & Light Co. v. Bell, 113 So. 2d 697, 698 (Fla. 1959)("[I]t must be shown that the allegedly conflicting cases are 'on all fours' in all material respects."); Nielsen v. City of Sarasota, 117 So. 2d 731 (Fla. 1960) (accord).

In the instant case, the Third and Fifth District decisions turn on disparate facts and legal theories, and different questions of law. This case involved a contract dispute between physicians and an HMO, over **covered** services rendered by the physicians to the HMO's commercial non-Medicare member/subscribers. The Third District scrupulously adhered to this Court's decision in Foundation Health v. Westside EKG Associates, 944 So. 2d 188 (Fla. 2006). It concluded that PPS was an intended beneficiary of HOI's non-Medicare member/subscriber contract (and incorporated statutes and regulations), which HOI breached when it refused to pay PPS. (App. 1-11).

Central States, Southeast & Southwest v. Florida Society of Pathologists, 824 So. 2d 935 (Fla. 5th DCA 2002), in contrast, is a tort case, which has nothing to do with HMOs or the obligations of an HMO pursuant to statute or regulation. Central States was a multi-employer/employee ERISA plan, with insureds in Florida. Central States successfully contended in federal court that the pathologists' bills were **not covered** under the terms of its plan, which was limited to "treatment." Id. at 937. Central States thus instructed its insureds by letter not to pay pathologists' bills, if billed directly. Id. at 936. The pathologists countered with a state tort suit against Central States, claiming that these letters tortiously

interfered with their business relationships and constituted "unfair and deceptive trade practices." Id. at 937.

The trial court entered a summary judgment, which declared that Central States had committed both torts. It further enjoined Central States from communicating its position to its insureds. Id. at 938. The Fifth District reversed, upon a holding that: (1) the physicians were unable to prove "interference with a business relationship shown by an actual and identifiable understanding or agreement" with **patients**, Id. at 940; or (2) that the patients were "legally obligated to pay for the professional component." Id. at 940.

In the instant case, all agreed that the disputed services **were covered** under the HOI's commercial non-Medicare member/subscriber contracts. The HMO **was** legally obligated to pay PPS by virtue of these contracts, which incorporated state statutes and regulations by reference. There was no reason for the Third District to mention, let alone discuss Central States. It was entirely inapposite.³

HOI's resort to the dissent in Fasig v. Florida Society of Pathologists, 769 So. 2d 1151 (Fla. 5th DCA 2000), is likewise unavailing. Dissents afford no basis for conflict jurisdiction. See Jenkins v. State, 385 So. 2d 1356 (Fla. 1980). In addition,

³ The Florida Star v. B.J.F., 530 So.2d 286, 289 (Fla. 1988) deals with the issue of jurisdiction in the limited context of the timing to file a petition for **certiorari** to the Supreme Court of the United States. It does not address what constitutes "express, direct conflict" under Fla. Const. art. V, §3(b)(3).

the only legal issue decided by Fasig was that the trial court did not abuse its discretion in refusing to permit the putative insureds to intervene in the Central States case. There is no express direct conflict between the Third District's decision and Fasig.

Finally, this Court was not imbued with conflict jurisdiction "to convert it into a court of selected errors whereby the Justices of this Court could whimsically select cases for review in order to satisfy some notion that the case would be of such importance as to justify the interest or attention of this Court." Nielsen v. City of Sarasota, 117 So. 2d 731, 734 (Fla. 1960). The Third District denied HOI's motion to certify this case, which argued that it presented a question of "great public importance." Absent "a real live and vital conflict" under the Florida Constitution, there is no basis for further review. Nielsen v. City of Sarasota, 117 So. 2d at 734.

CONCLUSION

For all of the foregoing reasons, the HMO's petition for review should be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was served via U.S. Mail/fax this _____ day of August, 2008 to:

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