[Cite as *Ohio Podiatric Med. Assn. v. Taylor*, 2012-Ohio-2732.]

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

The Ohio Podiatric Medical Association et al.,	:	
Plaintiffs-Appellants,	:	
v.	:	No. 11AP-916
	:	(C.P.C. No. 09CVH-11022)
Mary Taylor, Director and Superintendent of Insurance,	:	(ACCELERATED CALENDAR)
Defendant-Appellee.	:	

D E C I S I O N

Rendered on June 19, 2012

Law Office of Nanci L. Danison, LPA, and *Nanci L. Danison; McFadden Winner Savage & Segerman*, and *Mary Jane McFadden*, for appellants.

Michael DeWine, Attorney General, and *W. Scott Myers*, for appellee.

APPEAL from the Franklin County Court of Common Pleas

BRYANT, J.

{¶ 1} Plaintiffs-appellants, The Ohio Podiatric Medical Association, Bruce G. Blank, D.P.M., and Rebecca Lynn, appeal from a judgment of the Franklin County Court of Common Pleas granting the summary judgment motion of defendant-appellee, Mary Taylor, in her capacity as the director and superintendent of the Ohio Department of Insurance ("ODI"). Because (1) the trial court properly determined R.C. 3923.23 does not require parity of payment between podiatrists and other licensed physicians; (2) ODI did

not engage in illegal administrative rulemaking; and (3) plaintiffs suffered no prejudice from ODI's failure to hold a hearing on Dr. Blank's complaint, we affirm.

I. Facts & Procedural History

{¶ 2} On July 23, 2009, plaintiffs filed a complaint against ODI, seeking a declaratory judgment that: (1) ODI's issuing legal opinions to resolve complaints filed with it is an unlawful exercise of administrative authority; (2) ODI misinterpreted Ohio law when it concluded it lacks statutory authority to prohibit insurers from paying podiatric physicians less than other licensed providers for the same medical procedures; and (3) R.C. 3923.23 and R.C. 3901.20, in relation to R.C. 3901.21(W), require health insurance carriers to pay the same amount to podiatric physicians as to allopathic and osteopathic physicians for the same service. Underlying plaintiffs' complaint is their contention that, beginning in 2005 and 2006, some health insurance companies in Ohio adopted discriminatory reimbursement schedules "whereby podiatric physicians were paid less than allopathic or osteopathic physicians for performing the same medical procedures." (Complaint, at ¶ 14.)

{¶ 3} According to the complaint and the evidence subsequently presented in the parties' cross-motions for summary judgment, health insurance companies' disparate treatment of podiatrists, compared to other licensed physicians, dates back to the 1960s when health insurance companies "were refusing to reimburse patients for medical treatment obtained from podiatric physicians even though their insurance policies provided coverage for the services." (Complaint, at ¶ 8.) In 1969, the General Assembly responded by enacting R.C. 3923.23, which provides that reimbursement under a health insurance policy "shall not be denied" when a person licensed to practice osteopathic, optometric, chiropractic, or podiatric medicine renders a service otherwise covered by a health insurance policy. (Complaint, at ¶ 8.)

{¶ 4} "At the time ORC §3923.23 was enacted in 1969, reimbursement under health insurance policies was routinely made by the insurer directly to the policy holder after the policy holder submitted a physician's bill for a covered service to the insurer." (Complaint, at ¶ 9.) During the 1970s and 1980s, "following the Medicare model, health insurance carriers restructured their reimbursement systems so that * * * the physician-provider submitted the claim for payment directly to the insurer." (Complaint, at ¶ 9.)

Physicians now enter into provider agreements directly with insurance companies, and insurance companies are "third party payers," paying health care providers directly for services rendered to the companies' insureds. (Complaint, at ¶ 9, 15; Blank affidavit.)

{¶ 5} On March 8, 2005, ODI responded to an attorney who was inquiring whether an insurer could establish different benefit levels, and thus different levels of reimbursement, for physical therapy services depending upon the license of the practitioner providing the service. ODI answered "no," noting R.C. 3923.23 did "not prevent an insurer from placing a limitation on the total amount of coverage provided for a particular type of benefit or service, but the limitation must be based upon the type of service and not the type of license held by the provider." (Complaint, exhibit No. 1.)

{¶ 6} Later the same year, ODI responded on November 23, 2005 to questions the Ohio Optometric Association raised regarding the applicability of R.C. 3923.23 to insurers who established different reimbursement levels for covered services, depending on whether an optometrist or an ophthalmologist performed the service. (Complaint, exhibit No. 2.) ODI stated that, "[b]y its plain language, R.C. 3923.23 prohibits the *denial* of reimbursement for services that may be performed by a person pursuant to any of the specified licenses," but is "silent on the question as to whether the reimbursement level for that service may differ." (Emphasis sic.) (Complaint, exhibit No. 2.)

{¶ 7} In 2006, podiatrists, who were network physicians with Aetna and Anthem insurance companies, received notices explaining the insurers would reduce the fee amounts paid to podiatric physicians, effective November 1, 2006. Pursuant to the new fee schedules, the insurers were offering to pay podiatrists about one half the amount the insurer would pay to a medical doctor performing the same service. According to the insurance carriers, the podiatrists either had to agree to the lower payment rates or be dropped from the insurers' network; the insurance companies refused to negotiate the lower fees. The insurers cited ODI's November 2005 opinion letter to explain the new, reduced fee schedules.

{¶ 8} Dr. Blank averred he lost patients as a result of the fee schedules Aetna adopted. Plaintiff Rebecca Lynn, insured through Aetna, explained she was Dr. Blank's long-time patient and, after Dr. Blank removed himself from Aetna's network due to the

reduced benefit payments, Lynn could not afford Dr. Blank's services as an out-of-network physician.

{¶ 9} Dr. Blank, and other podiatric physicians, sent ODI complaints regarding the insurance carriers' reduced fee schedules. ODI responded by letter to the complaints, explaining reimbursement rates were "deemed to be private contractual matters between the provider and the third-party payer," so that ODI did "not have authority to resolve" the podiatrists' complaints. ODI emphasized that R.C. 3923.23 prohibited insurers from refusing to reimburse claims but did not address negotiation of rates between providers and insurers. (R. 78, exhibit No. 5, attachment G.)

{¶ 10} On December 17, 2008, ODI issued a legal memorandum "for distribution to the public," stating that, although R.C. 3923.23 required reimbursement for specified health care professionals, it did not authorize ODI "to require insurers to reimburse podiatrists (and other allied health care professionals) at the same rate as medical doctors for the same [current procedural terminology] code." (Complaint, exhibit No. 3.) ODI compared R.C. 3923.23 with statutes from Arkansas, Colorado, Illinois, and Maryland, all of which expressly required parity of payment. (Complaint, exhibit No. 3.) Contrasting these statutes, ODI concluded "Ohio's insurance laws require coverage, not payment parity." (Complaint, exhibit No. 3.)

{¶ 11} After the trial court resolved some discovery issues between the parties, ODI filed a Civ.R. 56 motion for summary judgment, noting no disputed issues of fact in the single issue of law plaintiffs' complaint presented: whether R.C. 3923.23 required parity of access or parity of reimbursement. ODI contended that, although the plain language of R.C. 3923.23 spoke to access and reimbursement in the first instance, it did not address the rate at which reimbursement was to be made.

{¶ 12} Plaintiffs filed a cross-motion for summary judgment, asking the court to declare: (1) ODI's December 2008 memorandum and November 2005 letter to be unlawful, because they authorized health insurance carriers to violate R.C. 3923.23; (2) the letters were, in effect, administrative rules not adopted in conformity with R.C. Chapter 119; and (3) ODI had a mandatory duty to conduct hearings on the podiatrists' complaints, but failed to do so.

{¶ 13} The trial court issued a decision and entry on October 3, 2011 denying plaintiffs' motion for summary judgment and granting ODI's motion for summary judgment. The trial court agreed with the parties that the language of the statute was "plain, unambiguous, and conveys a clear and definite meaning. * * * It prevents an insurance company from refusing to recognize the validity of a state-issued license to engage in the practice of those four specializations." (Decision, at 5.) The court, however, determined the statute did not "in any manner, contemplate or establish an amount of payment to be made from an insurance company to a provider." (Decision, at 6.) Noting that plaintiffs again raised the issue of improper administrative rulemaking, the court, per its earlier ruling in connection with discovery issues, stated its only function in the action was determining statutory construction.

II. Assignments of Error

{¶ 14} Plaintiffs appeal, assigning the following errors:

> [I.] THE COMMON PLEAS COURT ERRED IN HOLDING THAT R.C. 3923.23 DOES NOT CREATE EQUALITY OF POLICY BENEFITS/REIMBURSEMENT BETWEEN MDs AND DPMs WHEN "REIMBURSEMENT" ON ITS FACE MEANS REPAYMENT IN FULL AND THE GENERAL ASSEMBLY DECLARED R.C. 3923.23'S PURPOSE TO BE TO PROVIDE "FULL PROTECTION AND RECOMPENSE" TO PODIATRIC PHYSICIANS.
>
> [II.] THE COMMON PLEAS COURT ERRED BY NOT FINDING THE DEPARTMENT OF INSURANCE TO HAVE ENGAGED IN ILLEGAL ADMINISTRATIVE RULE MAKING WHEN IT PUBLISHED STANDARDS INTERPRETING R.C. 3923.23 AND 3901.21(W) WITHOUT COMPLYING WITH RC CHAPTER 119.
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> [III.] THE COMMON PLEAS COURT ERRED BY NOT FINDING THE DEPARTMENT OF INSURANCE TO HAVE FAILED IN ITS LEGAL DUTY TO HOLD A PRELIMINARY HEARING TO CONSIDER PLAINTIFFS' COMPLAINTS OF VIOLATION OF R.C. 3901.21(W).

III. Summary Judgment

{¶ 15} An appellate court's review of summary judgment is conducted under a de novo standard. *Coventry Twp. v. Ecker*, 101 Ohio App.3d 38, 41 (9th Dist.1995); *Koos v. Cent. Ohio Cellular, Inc.*, 94 Ohio App.3d 579, 588 (8th Dist.1994). Summary judgment is proper only when the parties moving for summary judgment demonstrate: (1) no genuine issue of material fact exists; (2) the moving parties are entitled to judgment as a matter of law; and (3) reasonable minds could come to but one conclusion and that conclusion is adverse to the party against whom the motion for summary judgment is made, that party being entitled to have the evidence most strongly construed in its favor. Civ.R. 56; *State ex rel. Grady v. State Emp. Relations Bd.*, 78 Ohio St.3d 181 (1997).

IV. First Assignment of Error – R.C. 3923.23

{¶ 16} Plaintiffs' first assignment of error asserts the trial court erred in holding that R.C. 3923.23 does not create "parity of payment" between podiatrists and other licensed physicians. R.C. 3923.23 states, in relevant part, that whenever an insurance policy "provides for reimbursement for any service which may be legally performed by a person licensed in this state for the practice of osteopathy, optometry, chiropractic, or podiatry, reimbursement under such policy or certificate shall not be denied when such service is rendered."

{¶ 17} Plaintiffs contend the trial court failed to apply "the clear and unambiguous legal definition of 'reimbursement' to" the statute. (Appellant's brief, at 4.) According to plaintiffs' argument, the term "reimbursement" in R.C. 3923.23 means "repayment of the full amount," so that the required statutory payment to a podiatrist "is what the [insurance] policy's benefit is when an MD performs the service." (Appellant's brief, at 4, 9.) ODI acknowledges "R.C. 3923.23 unambiguously provides that if an insurance policy provides reimbursement for a service provided by a physician then reimbursement cannot be denied on the basis that the service was provided by a podiatrist." (Appellee's brief, at 5.) It, however, asserts the statute does not "mandate that all practitioners be reimbursed equally." (Appellee's brief, at 5.)

{¶ 18} The paramount goal of statutory construction is to ascertain and give effect to the legislature's intent in enacting the statute. *Yonkings v. Wilkinson*, 86 Ohio St.3d 225, 227 (1999); *Brooks v. Ohio State Univ.*, 111 Ohio App.3d 342, 349 (10th Dist.1996), citing *Featzka v. Millcraft Paper Co.*, 62 Ohio St.2d 245 (1980). In so doing, the court

must first look to the plain language of the statute and the purpose to be accomplished. *State ex rel. Pennington v. Gundler*, 75 Ohio St.3d 171, 173 (1996) (internal quotations omitted). Words used in a statute must be accorded their usual, normal and customary meaning. *Id.*, citing R.C. 1.42. If the words in a statute are " 'free from ambiguity and doubt, and express plainly, clearly and distinctly, the sense of the law-making body, there is no occasion to resort to other means of interpretation.' " *State v. Hairston*, 101 Ohio St.3d 308, 2004-Ohio-969, ¶ 12, quoting *Slingluff v. Weaver*, 66 Ohio St. 621 (1902), paragraph two of the syllabus. " 'An unambiguous statute is to be applied, not interpreted.' " *Meeks v. Papadopulos*, 62 Ohio St.2d 187, 190 (1980), quoting *Sears v. Weimer*, 143 Ohio St. 312 (1944), paragraph five of the syllabus.

{¶ 19} " 'It is only where the words of a statute are ambiguous, uncertain in meaning, or conflicting that a court has the right to interpret a statute.' " *In re Adoption of Baby Boy Brooks*, 136 Ohio App.3d 824, 829 (10th Dist.2000), quoting *State ex rel. Burrows v. Indus. Comm.*, 78 Ohio St.3d 78, 81 (1997). "Ambiguity in a statute exists only if its language is susceptible of more than one reasonable interpretation." *Id.*, citing *State ex rel. Toledo Edison Co. v. Clyde*, 76 Ohio St.3d 508, 513 (1996). When construing an ambiguous statute, the court may consider a number of factors, including legislative history, the circumstances under which the statute was enacted, and the administrative construction of the statute. R.C. 1.49; *Family Medicine Found., Inc. v. Bright*, 96 Ohio St.3d 183, 2002-Ohio-4034, ¶ 9.

{¶ 20} Words in a statute that have acquired a technical or particular meaning, whether by legislative definition or otherwise, must be construed accordingly. R.C. 1.42. *See Montgomery Cty. Bd. of Commrs. v. Pub. Util. Comm.*, 28 Ohio St.3d 171, 175 (1986) (noting "[d]efinitions provided by the General Assembly are to be given great deference in deciding the scope of particular terms"). Under Ohio insurance law, " 'reimburse' means indemnify, make payment, or otherwise accept responsibility for payment for health care services rendered to a beneficiary, or arrange for the provision of health care services to a beneficiary." R.C. 3901.38(E).

{¶ 21} If the statutory definition of "reimbursement" is inserted into R.C. 3923.23, the statute then unambiguously provides that payment, indemnification, or responsibility for payment "shall not be denied" when one of the listed licensed professionals in the

statute performs a service covered in the insurance policy. The statute's purpose is apparent: insurance companies may not refuse to reimburse an insured for a covered service that a podiatrist, or any of the other named specialties in the statute, performs. R.C. 3923.23 nonetheless mentions neither rates of reimbursement nor equality of payment between the named specialties and other physicians.

{¶ 22} To reach plaintiffs' interpretation of R.C. 3923.23 would require us to add language to the statute indicating that payment, at the same rate as paid to other licensed physicians, shall not be denied when a podiatrist performs the service. Courts, however, have " 'no authority under any rule of statutory construction to add to, enlarge, supply, expand, extend or improve the provisions of the statute to meet a situation not provided for.' " *Storer Communications, Inc. v. Limbach*, 37 Ohio St.3d 193, 194 (1988), quoting *State ex rel. Foster v. Evatt*, 144 Ohio St. 65 (1944), paragraphs seven and eight of the syllabus (stating also that "[c]ourts have no legislative authority and should not make their office of expounding statutes a cloak for supplying something omitted from an act by the General Assembly)." Since the legislature could have included a statement in R.C. 3923.23 requiring parity of payment, but did not, we must assume the omission was intentional. *State ex rel. Gen. Elec. Supply Co. v. Jordano Elec. Co., Inc.*, 53 Ohio St.3d 66, 71 (1990) (declining "to read into the statute an intent that the General Assembly could easily have made explicit had it chosen to do so").

{¶ 23} Plaintiffs respond that *Knepper v. Travelers Ins. Co.*, 54 Ohio App.2d 9 (6th Dist.1977) interpreted "the same statutory language found in R.C. 3923.23 as requiring parity of payment." (Appellant's brief, at 8.) In *Knepper*, the plaintiffs suffered from a nervous disorder, incurred $1,728.75 for services of a licensed psychologist, and presented a claim for reimbursement of the incurred expenses to their insurer, Travelers Insurance Company. The plaintiffs' policy with Travelers provided that payment would "be made of 80% (65% For a mental or nervous disorder while not confined as an in-patient in a Hospital) of the charges * * * for covered medical expenses," covered expenses meaning charges "made by a licensed physician or trained nurse." *Id.* at 10-11. Travelers rejected the plaintiffs' claim, contending the insurance policy did not obligate it to pay for a psychologist's services.

{¶ 24} In resolving the issue, the court interpreted R.C. 3923.231, a sister statute of R.C. 3923.23 pertaining to psychologists, as "authoriz[ing] reimbursement for expenses for services of a qualified psychologist." *Id.* at 13. The court determined R.C. 3923.231 became "part of the Travelers group insurance contract * * * as fully as if such statute were written into such contract," entitling the plaintiffs to coverage under the terms of the policy. *Id.* at 13, 14. *Knepper*, however, did not address parity of payment, concluding only that the plaintiffs were entitled to reimbursement under the statute. Indeed, *Knepper* demonstrates the parameters of R.C. 3923.23: both R.C. 3923.231 and 3923.23 prohibit the insurer from refusing to reimburse the insured on a presented medical claim for expenses an insured incurs as a result of the services of a licensed individual listed in the statute.

{¶ 25} Moreover, *Knepper* is no longer consistent factually with circumstances since the onset of managed care, where generally insureds no longer present their claims for reimbursement directly to their insurer. Rather, physicians contract to be a member of an insurer's network at a certain rate, and the insurer as a third-party payer pays the physician directly for services rendered to an insured. The change, however, does not permit us to interpret differently the unambiguous language of R.C. 3923.23. "A court may not construe [a statute] so as to change the clear meaning of a statute to suit the particular facts of a case at bar." *Wilson v. S. Cent. Local School Dist.*, 107 Ohio App.3d 610, 613 (6th Dist.1995), citing *Wachendorf v. Shaver*, 149 Ohio St. 231 (1948).

{¶ 26} Plaintiffs contend the two letter opinions ODI issued in 2005 demonstrate, if nothing else, that R.C. 3923.23 is "susceptible of more than one reasonable interpretation" and thus requires the trial court to consider the statute's legislative history. (Appellant's brief, at 6.) Although the two letters from 2005 arguably conflict, they do not change the language of R.C. 3923.23 from unambiguous to ambiguous. *See Columbus Check Cashers, Inc. v. Cary*, 196 Ohio App.3d 132, 2011-Ohio-1091, ¶ 12 (10th Dist.), quoting *Taber v. Ohio Dept. of Human Servs.*, 125 Ohio App.3d 742, 747 (10th Dist.1998), quoting *Wachendorf* at paragraph five of the syllabus; R.C. 1.49(F).

{¶ 27} Moreover, even if we were to examine the statute's legislative history, it does not aid plaintiffs' argument. Am.S.B. No. 240, 132 Ohio Laws, Part II, 2239 ("Am.S.B. 240") introduced in the 1967-1968 session of the Ohio General Assembly, states the

statute, enacted as R.C. 3923.041 and later re-numbered R.C. 3923.23, is designed "to guarantee[] full protection and recompense for insured risk under sickness and accident insurance contracts providing for reimbursement of sickness and bodily injury claims." (R. 78, exhibit No. 9.) Confirming the legislative purpose, the legislative service commission report dated July 21, 1967 states Am.S.B. No. 240 was "intended to prevent discrimination against the four named specialties in sickness and accident policies which limit reimbursement to a physician or surgeon." (R. 78, exhibit No. 11.)

{¶ 28} The General Assembly's intent in enacting R.C. 3923.23 thus was to require health insurers to reimburse insureds when one of the named specialties performed a service the policy of insurance covered. Nothing in the language of the statute or the legislative service commission commentary suggests the General Assembly intended R.C. 3923.23 to apply to contracts entered into directly between the insurer and the physician-provider, much less to require parity of payment between the named specialties and other physicians.

{¶ 29} Finally, all statutes relating to the same subject matter " ' "must be read *in pari material*" ' " and construed together so " ' "as to give the proper force and effect to each and all such statutes." ' " *State v. Cook*, 128 Ohio St.3d 120, 2010-Ohio-6305, ¶ 45, quoting *United Tel. Co. of Ohio v. Limbach*, 71 Ohio St.3d 369, 372 (1994), quoting *Johnson's Mkts., Inc. v. New Carlisle Dept. of Health*, 58 Ohio St.3d 28, 35 (1991). R.C. Chapter 1751, governing health insuring corporations, specifically allows insurers to treat the licensed individuals listed in R.C. 3923.23 differently from other physicians. R.C. 1751.51 provides that if a health care plan covers services which "may be legally performed by a class of providers referred to in" R.C. 3923.23, "but would restrict an enrollee's ability to receive these health care services from members of that class in any manner that differs from an enrollee's ability * * * to receive these * * * services from any other class of providers" who may legally perform these services, the health insuring corporation must provide, within the enrollee's health care plan, "a clear, concise, and complete statement of the restriction." R.C. 1751.51(A). Rather than require equal treatment, the statute requires disclosure of unequal treatment.

{¶ 30} Because (1) the unambiguous language of R.C. 3923.23 requires reimbursement not be denied when a podiatrist performs a service covered in a policy of

insurance; but (2) the statute does not mention rates of payment; and (3) another statutory provision specifically permits insurers to treat podiatrists differently from licensed physicians, we are constrained to conclude R.C. 3923.23 does not require parity of payment. Accordingly, plaintiffs' first assignment of error is overruled.

V. Second & Third Assignments of Error – Illegal Administrative Rulemaking and Failure to Hold a Hearing

{¶ 31} Plaintiffs' second assignment of error asserts the trial court erred in not concluding ODI engaged in illegal administrative rulemaking. Plaintiffs' third assignment of error asserts the trial court erred in not determining ODI was statutorily required to hold a hearing on plaintiffs' complaints. Although the trial court did not address specifically either contention, its interpretation of R.C. 3923.23 tacitly resolved them.

{¶ 32} In response to plaintiffs' contentions, ODI maintains neither issue is a proper subject for a declaratory judgment action. "[C]ourts of record may declare rights, status, and other legal relations whether or not further relief is or could be claimed." R.C. 2721.02(A). Any person "whose rights, status, or other legal relations are affected by a * * * statute, [or] rule as defined in section 119.01 * * * may have determined any question of construction or validity arising under the * * * statute, [or] rule * * * and obtain a declaration of rights, status, or other legal relations under it." R.C. 2721.03. *See Aust v. Ohio State Dental Bd.*, 136 Ohio App.3d 677, 681 (10th Dist.2000) (noting the essential elements for declaratory relief are: (1) a real controversy exists between the parties; (2) the controversy is justiciable in character; and (3) speedy relief is necessary to preserve the rights of the parties). As a result, the two issues plaintiffs raise properly can be resolved in a declaratory judgment action per the parameters of the noted statutes. *See, e.g., Ohio Dental Hygienists Assn. v. Ohio State Dental Bd.*, 21 Ohio St.3d 21, 22 (1986) (concluding appellants properly filed a declaratory judgment action "seeking a determination of whether the board's letter was invalid as non-compliant with the rule-making provisions of R.C. Chapter 119").

A. *Illegal Administrative Rulemaking*

{¶ 33} Plaintiffs assert ODI's letter issued in November 2005 and legal memorandum issued in December 2008 are, in reality, illegally adopted administrative

rules. ODI responds that the opinions were simply "intended as an answer to a question and not as a means to enforce an action against a licensee." (Appellee's brief, at 11.)

{¶ 34} A "rule" means "any rule, regulation, or standard, having a general and uniform operation, adopted, promulgated, and enforced by any agency," and does not include "any internal management rule of an agency unless the internal management rule affects private rights." R.C. 119.01(C). Agencies statutorily authorized to adopt rules must "comply with the procedure prescribed in sections 119.01 to 119.13 * * * for the adoption * * * of rules, [and] the failure of any agency to comply with such procedure shall invalidate any rule." R.C. 119.02. *See also* R.C. 3901.041 (providing that the superintendent of insurance has the authority to "adopt, amend, and rescind rules * * * to discharge the superintendent's duties," subject to R.C. Chapter 119).

{¶ 35} " 'It is the effect of the [document], not how the [agency] chooses to characterize it,' " that determines whether a document issued from an agency constitutes a rule. *State ex rel. Saunders v. Indus. Comm.*, 101 Ohio St.3d 125, 2004-Ohio-339, ¶ 26, quoting *Ohio Nurses Assn., Inc. v. Ohio State Bd. of Nursing Edn. & Nurse Registration*, 44 Ohio St.3d 73, 76 (1989). "The pivotal issue in determining the effect of a document is whether it enlarges the scope of the rule or statute from which it derives rather than simply interprets it." *Saunders* at ¶ 27, citing *Ohio Nurses*; *OPUS III–VII Corp. v. Ohio Bd. of Pharmacy*, 109 Ohio App.3d 102, 113 (10th Dist.1996). "If the former, it must be promulgated pursuant to R.C. Chapter 119. If the latter, it is exempt from those requirements." *Id.*

{¶ 36} To illustrate the distinction, the Supreme Court in *Saunders* compared the documents at issue in *Ohio Nurses* with those in *OPUS*. In *Ohio Nurses*, "the State Nursing Board issued a 'position paper' that greatly expanded the authority of licensed practical nurses ('LPNs') to administer intravenous fluids or 'IVs.' " *Saunders* at ¶ 28. The court determined the position paper was a rule, subject to the R.C. Chapter 119 promulgation requirements, "because it expanded the scope of LPN practice[,] * * * regulated those LPNs qualified to start IVs by requiring additional course work," and " 'establish[ed] a new rule, standard or regulation regarding LPN practice.' " *Id.* at ¶ 29-30, quoting *Ohio Nurses* at 76. *See also Livisay v. Ohio Bd. of Dietetics*, 73 Ohio App.3d 288 (10th Dist.1991).

{¶ 37} In *OPUS*, the Ohio State Board of Pharmacy responded to an inquiry from one of its licensed distributors regarding whether the distributor could return unused medication dispensed in an OPUS container to a pharmacy for credit. *Saunders* at ¶ 36; *OPUS* at 106-07. Construing the term "unopened" in Ohio Adm.Code 4729-9-04, the board determined that whether an OPUS container had been opened was impossible to ascertain, prompting the board to conclude "medication dispensed in OPUS containers could not be returned and redispensed." *Saunders* at ¶ 36. "OPUS objected, arguing that the board had implicitly added the requirement that packaging be 'tamper-evident,' and, in so doing, created a new rule without complying with R.C. Chapter 119." *Saunders* at ¶ 37. The *OPUS* court concluded that, in contrast to the document in *Ohio Nurses*, the pharmacy board's letter "merely interpreted the language used in an existing rule, but did not establish a new rule, standard or regulation." *Id.* at 113.

{¶ 38} Here, the November 2005 letter and the December 2008 legal memorandum interpreted the language used in R.C. 3923.23, but did not purport to expand duties or establish a new rule, regulation, or standard. Moreover, ODI's interpretation of R.C. 3923.23 is consistent with the language of the statute. *See OPUS* at 113, citing *Jones Metal Prods. Co. v. Walker*, 29 Ohio St.2d 173, 181 (1972). Because the documents do no more than apply the plain language of the statute, plaintiffs do not demonstrate a violation of ODI's rule-making authority.

{¶ 39} Accordingly, plaintiffs' second assignment of error is overruled.

B. *Failure to Hold a Hearing*

{¶ 40} Plaintiffs' third assignment of error asserts the trial court erred in granting summary judgment to ODI on plaintiffs' claim that ODI failed to hold preliminary hearings on plaintiffs' complaints regarding the fee schedules insurers were applying to podiatric services. Dr. Blank's complaint to ODI alleged that Aetna's fee schedule violated R.C. 3923.23 and constituted an unfair trade practice under R.C. 3901.21(W). R.C. 3901.21(W) defines an unfair or deceptive act or practice in the business of insurance to include failing to comply with R.C. 3923.23. R.C. 3901.20 prohibits any person from engaging in an unfair or deceptive act or practice in the business of insurance.

{¶ 41} R.C. 3901.22(A) provides that the "superintendent of insurance may conduct hearings to determine whether" R.C. 3901.20 has been violated. The

superintendent "shall hold" such a hearing if the superintendent finds that "the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds are established, and that such grounds otherwise justify holding such a hearing." R.C. 3901.22(A).

{¶ 42} Plaintiffs contend *Ohio Academy of Trial Lawyers v. State of Ohio, Dept. of Ins.*, 10th Dist. No. 81AP-497 (Mar. 2, 1982), *aff'd*, 4 Ohio St.3d 201 (1983), interpreted R.C. 3901.22(A) as requiring ODI to hold a preliminary hearing on complaints alleging a violation of R.C. 3901.21(W). Plaintiffs focus on the language in *Ohio Academy*, explaining that "R.C. 3901.22 contemplates a bifurcated procedure." *Id.* "First, upon the application, the superintendent conducts a preliminary hearing to determine whether or not adequate grounds have been alleged in the application to justify holding a hearing." *Id.* The determination at this initial stage is whether "the applicant acts in good faith and would be aggrieved by the act alleged to be in violation of law or insurance rule and whether the grounds alleged justify holding a hearing." *Id.*

{¶ 43} Plaintiffs contend the "unrefuted evidence establishes that the complaints were made in good faith, that podiatric physicians are aggrieved, and that admitted violations of R.C. 3923.23 and 3901.21(W) justify holding a hearing." (Appellant's brief, at 14.) Based on our resolution of plaintiffs' first assigned error, however, Dr. Blank was not aggrieved, as the fee schedule Aetna adopted did not constitute a violation of R.C. 3923.23. Accordingly, even if a hearing were required, plaintiffs suffered no prejudice in ODI'S failure to conduct a hearing.

{¶ 44} Plaintiffs' third assignment of error is overruled.

VI. Disposition

{¶ 45} Plaintiffs assert ODI's interpretation of R.C. 3923.23 permits insurers conceivably to agree to pay podiatrists one cent for services that other physicians receive hundreds of dollars to perform. To the extent an insurer were to compensate a podiatrist at a drastically reduced rate compared to other physicians, the insurer may cross the line from issues of reimbursement amount to refusal to reimburse in violation of the statute. On the facts before us, we acknowledge that the disparity of payment may well deserve a remedy, but remedy does not lie with the court. "The court has nothing to do with the wisdom or unwisdom of the provisions of the statute, and if its plain terms, reasonably

construed, do not give the relief desired, the remedy lies with the legislative branch of the state government." *Miller v. Fairley*, 141 Ohio St. 327, 334 (1943), citing *State ex rel. Bishop v. Bd. of Edn. of Mt. Orab Village School Dist.*, 139 Ohio St. 427, 438 (1942).

{¶ 46} Having overruled plaintiffs' three assignments of error, we affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

BROWN, P.J., and DORRIAN, J., concur.
