Report from The Office of Medical Services to the Three-Member Panel Regarding the Resolution of Medical Reimbursement Disputes and Actions Pursuant to s. 440.13(8), Florida Statutes, During Fiscal Year 2007 - 2008

May 29, 2009
Department of Financial Services
Division of Workers' compensation
Fiscal Year 2007 - 2008

Introduction and Overview

The Office of Medical Services (OMS) administers four programs pursuant to s. 440.13, Florida Statutes (F.S.): certification of health care providers; certification of Expert Medical Advisers; determination of whether any health care provider has engaged in a pattern or practice of overutilization or a violation of the Workers' Compensation Law or administrative rules; and resolution of reimbursement and utilization disputes concerning medical services.

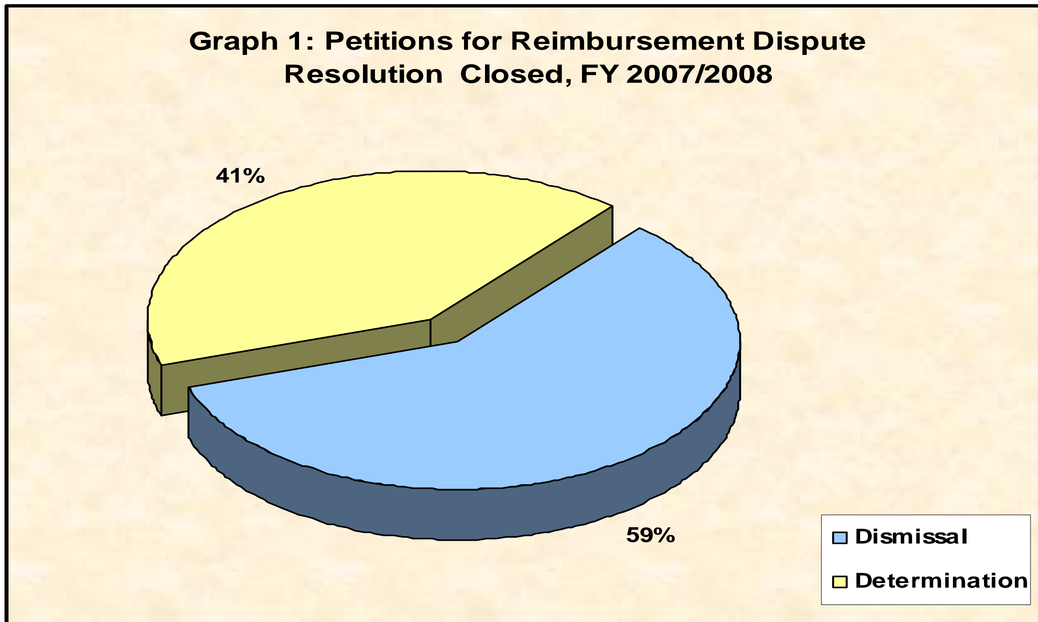
The OMS has been managed by the Department of Financial Services (Department), Division of Workers' Compensation (Division) under an Interagency Agreement between the Department and the Agency for Health Care Administration (AHCA) from November, 2005, through June 30, 2008. The OMS was formally transferred to the Division on July 1, 2008.

Pursuant to s. 440.13(12)(e)(4), F.S., "The Department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to s. 440.13(8)." The following report provides a detailed accounting of the Petitions for Resolution of Reimbursement Dispute received and adjudicated as well as activity generated by Carrier Reports of Over-Utilization for Fiscal Year 2007 – 2008.

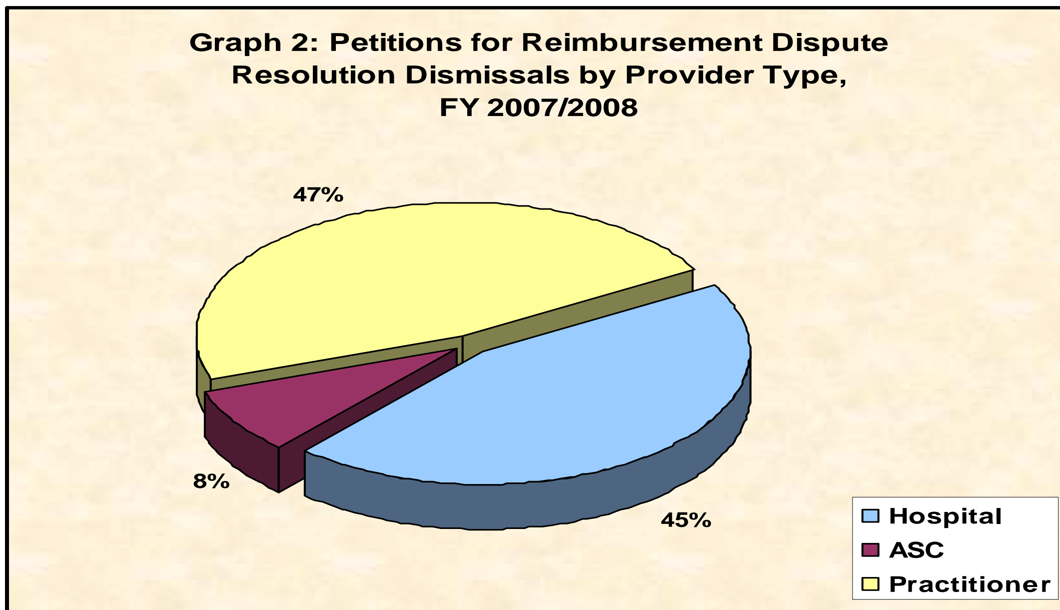
The OMS has implemented significant process changes in handling the resolution of reimbursement and utilization disputes as a result of the revisions to Rule 59A-31, Florida Administrative Code (F.A.C.), Resolution of Workers' Compensation Reimbursement Disputes, November 28, 2006. Consequently, the OMS has been able to process an increasing number of disputes. For the purpose of this report, classification of disputes is according to provider type, whether the decision rendered is a Determination or Dismissal, and the reason for the Determination or Dismissal.

Utilization and Reimbursement Disputes, s. 440.13(7), F.S.

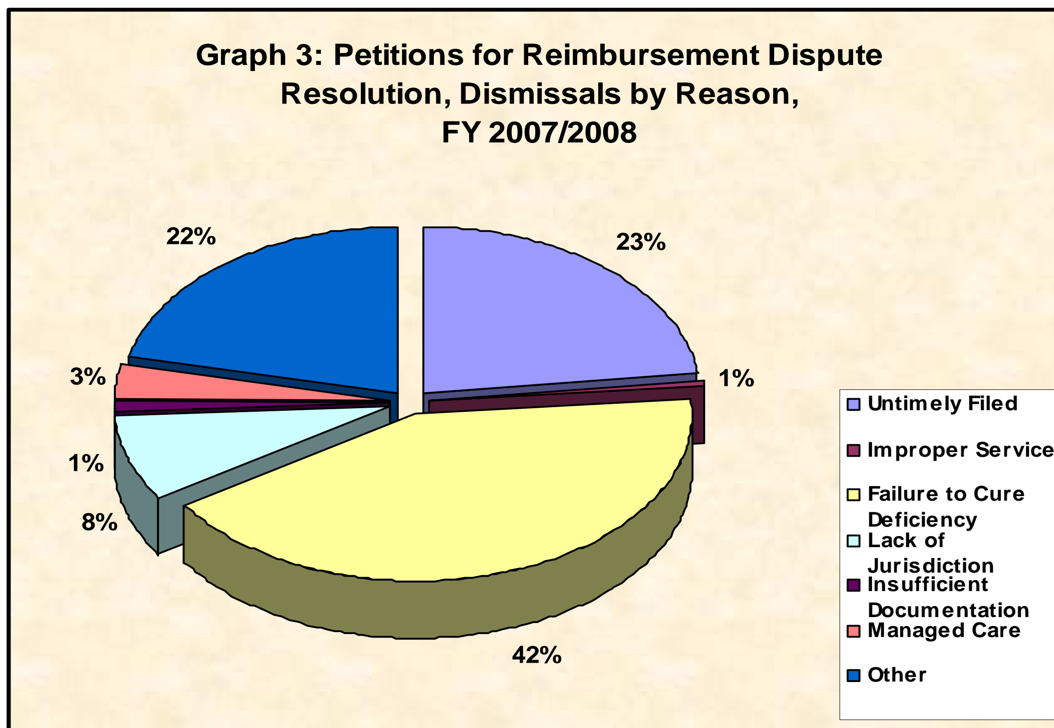
Graph 1 below illustrates the total number of Petitions for Resolution of Reimbursement Dispute closed during FY 2007/2008. Of the 1921 petitions, 1130 or 59% received a Dismissal and 791 or 41% received a Determination.



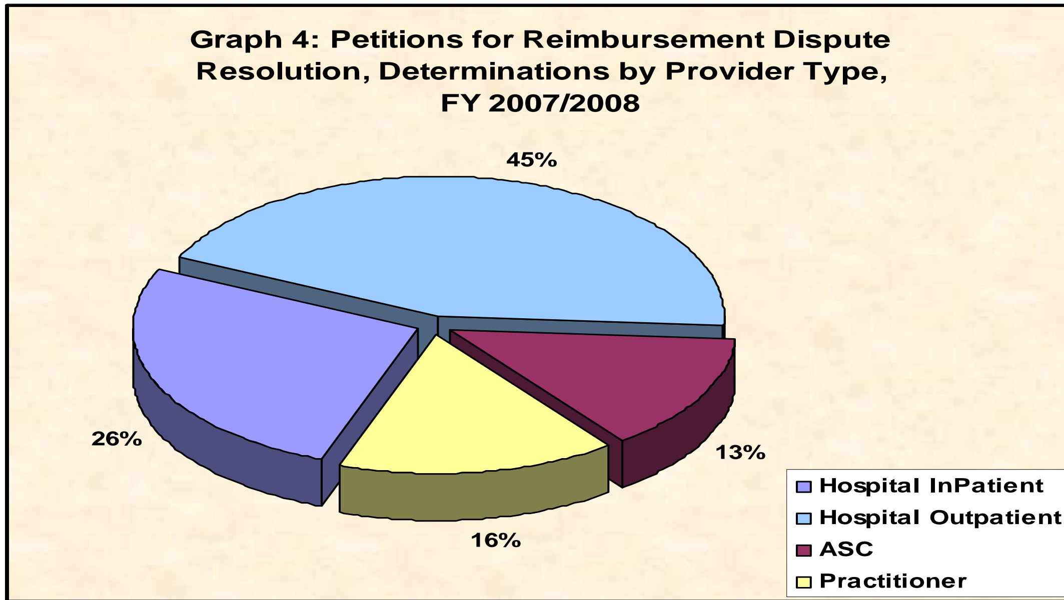
Graph 2 below illustrates the total number of Petitions for Resolution of Reimbursement Dispute that were issued a Dismissal during FY 2007/2008 by provider type. Of the 1130 petitions that were dismissed, 509 or 45% were submitted by hospitals, 92 or 8% were submitted by ambulatory surgical centers (ASC) and 529 or 47% were submitted by Practitioners.



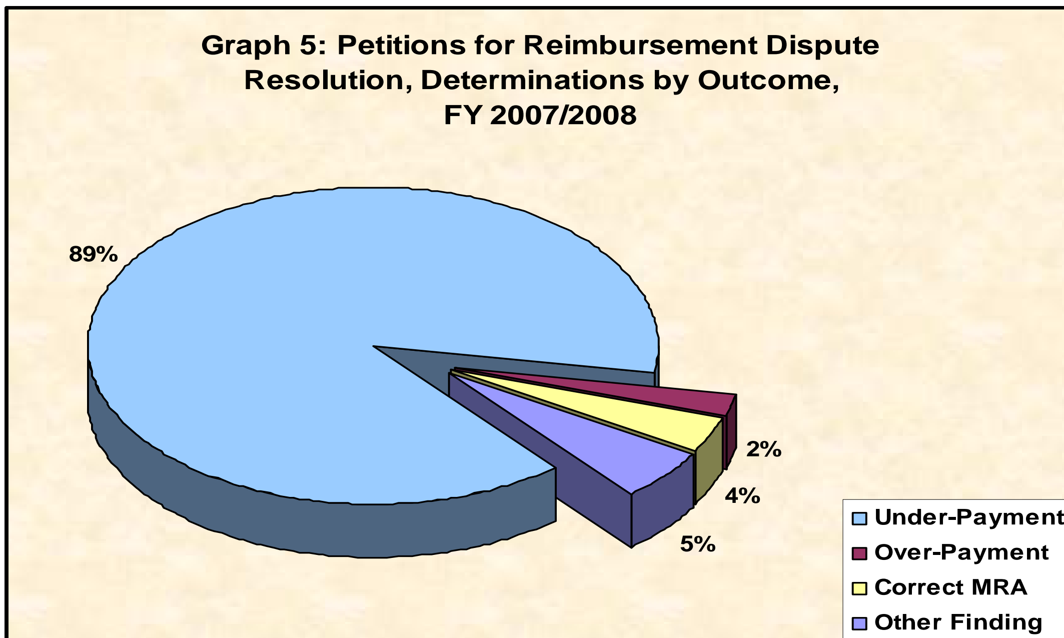
Graph 3 below illustrates the reasons for which the Petitions for Resolution of Reimbursement Dispute were Dismissed during FY 2007/2008. A petitioner has 30 days within which the petitioner may submit a petition to the OMS to dispute the reimbursement received from the carrier. A petition that is untimely filed refers to a petition that was submitted more then 30 days after receipt of the Explanation of Bill Review (EOBR) by the petitioner. Pursuant to Rule 69L-7.602(5)(q), F.A.C., a carrier must designate an entity to receive service of a petition for reimbursement dispute on the EOBR. A petition served on an entity other then the entity listed on the EOBR for service receives a Notice of Deficiency, pursuant to Rule 59A-31, F.A.C., and the petitioner is given 10 days from receipt of the Notice of Deficiency to respond with service on the entity designated on the EOBR. If the petitioner does not respond or does not serve a copy of the petition on the entity designated on the EOBR, the petition is dismissed for improper service. When an incomplete petition is received, a Notice of Deficiency is sent to the petitioner and the petitioner is given 10 days from receipt of the Notice of Deficiency to cure the deficiency. If the Notice of Deficiency is not cured within the 10 days, the petition is dismissed for failure to cure the deficiency. However, if a response from a Notice of Deficiency is received, but the response does not contain all the curative documentation requested, the petition is dismissed for insufficient documentation. When a petition is received that does not fall under the jurisdiction of workers' compensation, e.g., the petitioner is not a health care provider or the injured employee is not covered by Florida's workers' compensation law, the petition is dismissed for lack of jurisdiction. Services rendered pursuant to a managed care arrangement may not be contested under s. 440.13(7), F.S., and are dismissed. Finally, petitions that are dismissed under the "other" category may be because of a withdrawal by the petitioner, a settlement agreement, or some other formal notice by the petitioner that no further assistance is required from the OMS. Of the 1130 petitions Dismissed during FY 2007/2008, nine (1%) were for Improper Service; 15 (1%) for Insufficient Documentation; 35 (3%) for Managed Care; 92 (8%) for Lack of Jurisdiction; 243 (22%) for Other Reason; 259 (23%) for Untimely Filed; and 477 (42%) for Failure to Cure Deficiency.



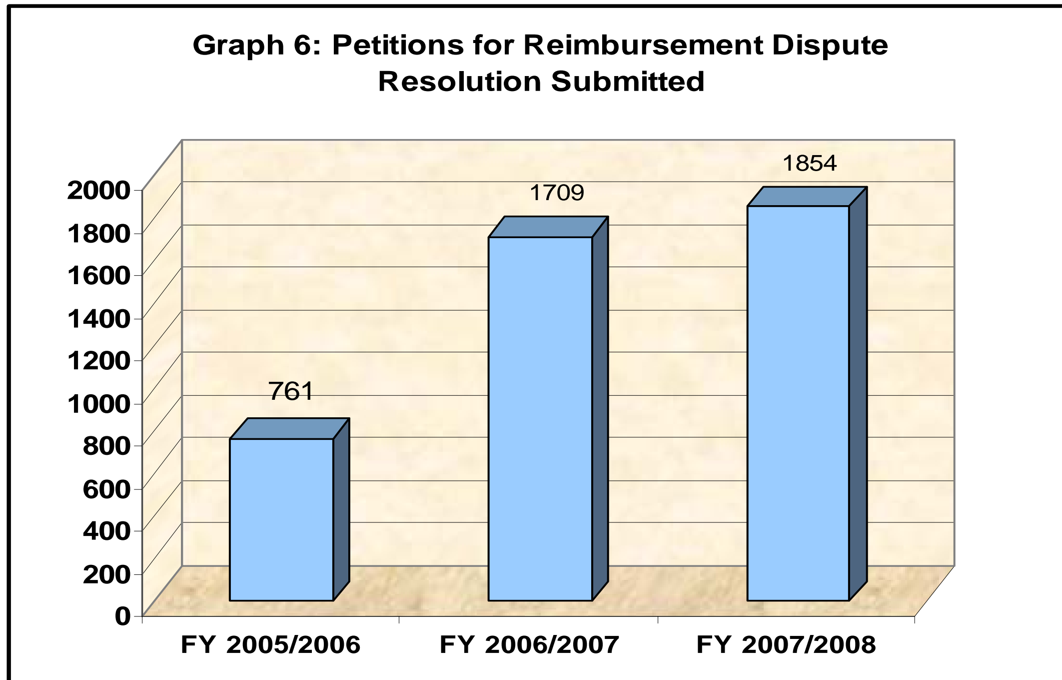
Graph 4 below illustrates the total number of Petitions for Resolution of Reimbursement Dispute for which a Determination was issued during FY 2007/2008 by provider type. Of the 791 accepted petitions, 71% were submitted by hospitals, 13% by ASC's and 16% by practitioners. The hospital Determinations are further distinguished by outpatient or inpatient stay: 26% were for inpatient care and 45% were for outpatient care.



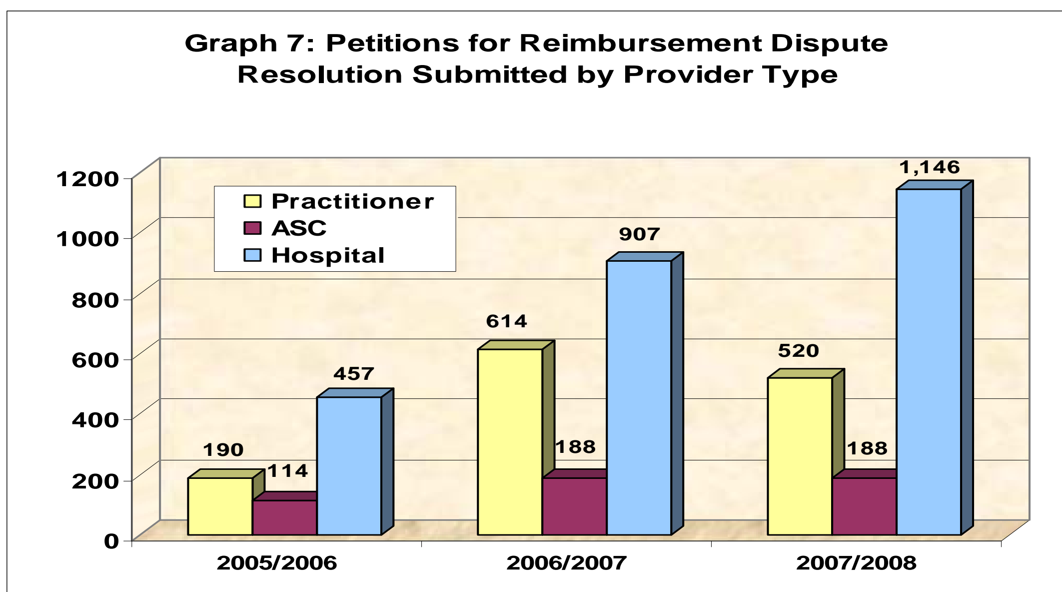
Graph 5 below illustrates the total number of Petitions for Resolution of Reimbursement Dispute for which a Determination was issued during FY 2007/2008, by determination outcome. Of the 791 Determinations issued, 17 (2%) were for Overpayment; 29 (4%) were for Correct Maximum Reimbursement Allowance (MRA); 63 (5%) for Other reasons (no additional payment due, contract); and 704 (89%) for Underpayment.



Graph 6 below illustrates the total number of Petitions for Resolution of Reimbursement Dispute received during each of the last three fiscal years. As the graph indicates, the number of petitions submitted has increased annually resulting in a 144% increase from the number of petitions submitted in FY 2005/2006 to those submitted in FY 2007/2008.



Graph 7 below illustrates the total number of Petitions for Resolution of Reimbursement Dispute received during each of the last three fiscal years by provider type. The number of petitions received from hospitals increased by 151% from FY 2005-2006 to FY 2007-2008. The number of hospital petitions submitted exceeds the combined number of petitions submitted by ASCs and Practitioners during each of the three fiscal years cited.

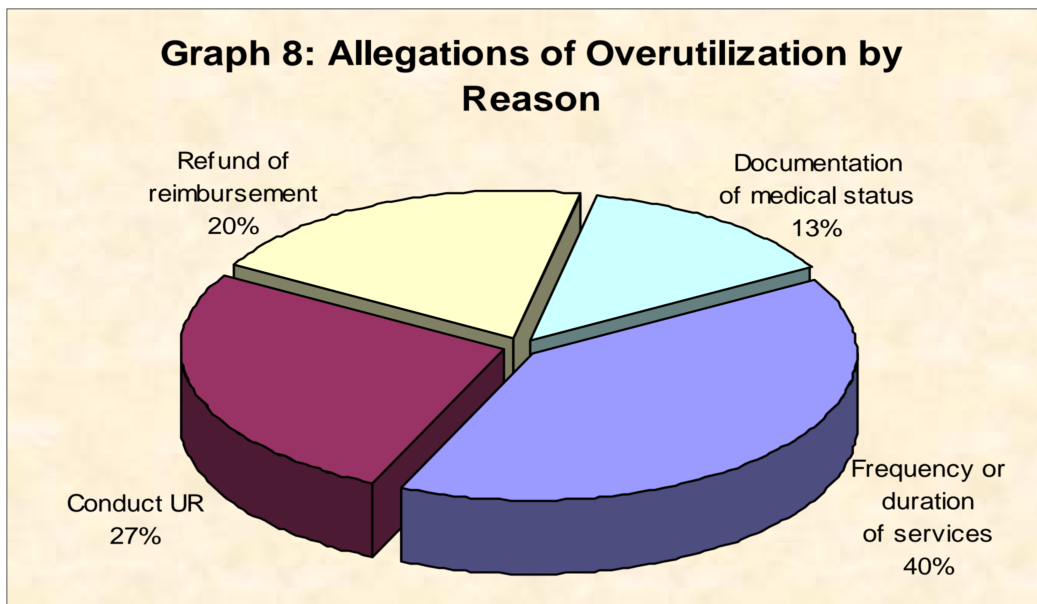


Pattern or Practice of Overutilization, s. 440.13(8), F.S.

Section 440.13(8), F.S. specifically mandates that carriers report to the department all instances of overutilization, including, but not limited to, all instances in which the carrier disallows or adjusts payment or makes a determination that the provided or recommended treatment is in excess of the practice parameters and protocols of treatment established in Chapter 440, F.S. The carrier is required to identify overutilization and billing errors pursuant to the carrier utilization review functions established under s. 440.13(6), F.S. Upon confirming that either a pattern or practice of overutilization or other violations of the workers' compensation law or rules exists, the department has discretion to impose penalties against providers.

During the FY 2007/2008, the OMS received fifteen carrier reports pursuant to s. 440.13(8), F.S., from carriers or carrier representatives alleging overutilization or other violations of Chapter 440, F.S. Fourteen of the reports involved allegations against physicians licensed under the Board of Medical Examiners and one involved a physician licensed by the Board of Chiropractic.

As illustrated in Graph 8 below, forty percent of the reports related specifically to the frequency or duration of services rendered. Slightly more then a quarter of the reports to the Department requested the OMS to conduct utilization review to determine whether the billed services constituted overutilization. The remaining two categories related to alleged violations of specific obligations by providers participating in the workers' compensation system.



OMS closed fourteen of the fifteen cases received during the reporting period without imposing administrative penalties pursuant to s. 440.13(8) and (13), F.S.

Twelve of the cases closed were related to a retrospective review of medical services rendered by authorized providers: five alleged overutilization, four requested OMS to conduct utilization review, and three requested refunds of overpayments. In all but one of the twelve cases closed, the OMS determined that the carrier failed to properly implement an authorization process consistent with the requirements of s. 440.13(3), F.S., or to review medical bills to disallow or adjust payment for treatment that constituted

overutilization of services or billing errors pursuant to s. 440.13(6), F.S. However, in one case, the OMS issued a Notice of Receipt of Referral for Overutilization of Service that advised the provider of the requirement to render only medically necessary care pursuant to the Standards of Care provisions in s. 440.13(16), F.S., and the potential imposition of penalties pursuant to s. 440.13(8) and (13), F.S., if, upon further investigation, the OMS determined that the provider has a pattern or practice of overutilization pursuant to s. 440.13(11), F.S.

The remaining two cases were related to violations of s. 440.13(4)(a) and (c), F.S., and s. 440.15(3)(d), F.S., or rules adopted by the Department. The OMS issued Educational Letters to the providers reiterating their responsibilities under Chapter 440, F.S., to communicate the medical condition or submit medical records to the carrier upon request and to document the injured employees Maximum Medical Improvement date and Permanent Impairment rating for submission to the carrier.

One case remains open for expanded investigation of additional cases related to the frequency and duration of pain management services rendered by the physician.