CHIEF FINANCIAL OFFICER
JEFF ATWATER
STATE OF FLORIDA

Report to the Three-Member Panel Regarding the Resolution of Medical Reimbursement Disputes and Actions Pursuant to Section 440.13(12)(e), Florida Statutes

Fiscal Year 2013-2014

Florida Department of Financial Services
Division of Workers' Compensation
Medical Services Section
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Introduction and Overview

The Department of Financial Services is required, upon request, to produce an annual report to the Three-Member Panel regarding the resolution of reimbursement disputes and actions regarding reports of health care provider violations pursuant to Section 440.13(12)(e), Florida Statutes (F.S.). The Medical Services Section (formerly known as the Office of Medical Services), located within the Division of Workers' Compensation (Division), has prepared this report and analysis, which relies upon data captured by the Division, as of July 2014.

The Medical Services Section administers four programs pursuant to Section 440.13, F.S.: policy development and implementation of several reimbursement manuals; certification of Expert Medical Advisors; 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. This report will highlight the activities within the latter two programs during Fiscal Year (FY) 2013–2014.

I. Report on Patterns or Practices of Overutilization by Health Care Providers

Pursuant to the provisions in subsections 440.13(8), and (11), F.S., the Department is granted authority to determine if a health care provider has engaged in a pattern or practice of overutilization of services in rendering medical care and treatment under the Florida Workers' Compensation health care delivery system. A pattern or practice of overutilization of services occurs when a physician renders care not medically necessary or appropriate for the compensable condition in one or more cases under the physician's care. To determine if physicians are engaging in patterns or practices of overutilization or any violation of Chapter 440, F.S., the Department implemented its health care provider violation referral process to investigate complaints from industry partners and to review paid medical claims data, filed by Workers' Compensation insurers, indicative of potentially aberrant medical practices.

The health care provider referral process, incorporated in Rule Chapter 69L-34, F.A.C., Carrier Report of Health Care Provider Violation, provides an elective process by which insurers report alleged instances of overutilization of services, which is in addition to medical bill data reporting/filing requirements in Rule 69L-7.740, F.A.C., Insurer Authorization and Medical Bill Review Responsibilities.

An alleged violation must be submitted on the DFS-F6-DWC 2000 Form, Health Care Provider Violation Referral Form, and must be accompanied by medical documentation to reasonably support the alleged violation. Acceptable supporting documentation must include, at a minimum, two peer review reports or two Independent Medical Examination reports addressing the appropriateness of the care under review. The opinions rendered in the reports must be corroborated by evidence-based medical literature and practice guidelines, widely accepted in the medical community.

During FY 2013-2014, the Department processed[1] eleven violation referrals, filed by insurers or entities acting on behalf of an insurer, alleging overutilization of services. Seven of the referrals were received during this reporting period. The remaining four referrals were carried over from previous fiscal years as active cases. Of the eleven cases processed, nine referrals were filed against physicians licensed under the Board of Medical Examiners, one against a physician licensed under the Board of Chiropractic Medicine and one against an Advanced Registered Nurse Practitioner.

The violation types processed during FY 2013-2014 include nine for overutilization of services, one for improper medical record documentation, and one for practicing outside the scope of the medical license.

Only five of the eleven referrals for an alleged violation were reasonably supported by documentation. Consequently, in four of these cases, the Department procured the opinion of an Expert Medical Advisor (EMA)[2], pursuant to s. 440.13(9), F.S., to address the appropriateness of the level and quality of services questioned by the insurer. The fifth case did not require an EMA opinion as the practitioner's licensure does not permit it to address maximum medical improvement and permanent impairment ratings under the system.

1 Processed means the Department reviewed a case to determine the sufficiency of the referral submission, to confirm the presence of corroborating evidence of the allegation and to evaluate the need for Expert Medical Advisor services to address the supported allegation. Possible outcomes of the Department's review are closure for insufficient submission or failure by insurer to substantiate the overutilization or other Standard of Care violations; or issuance of a finding of violation.

2 An Expert Medical Advisor is a physician certified by the Department to provide expert opinion to the Department in facilitating the resolution of utilization of services disputes between an insurer and a treating physician. EMA services procured by the Department are authorized pursuant to s. 440.13(9), F.S., and consist of the retrospective review of the medical services rendered in the case under review.

The role of the EMA is to conduct retrospective medical record reviews to address whether rendered services constituted overutilization or other Standard of Care violations; to identify alternative treatment more appropriate for the compensable condition; and to cite the medical literature upon which the EMA opinion is based. The Department considers the EMA's opinion when determining if a physician has engaged in a violation, to include overutilization of services, and if the imposition of an administrative sanction is appropriate.

The following table reflects the outcome of the eleven case files processed this reporting period.

OUTCOME OF 11 PROCESSED CASES FY 2013-2014	
Open	2
No Finding of Violation (Closed)	6
W/Finding of Violation & Penalty (Closed)	2
W/Finding of Violation No Penalty (Closed)	1

A total of nine cases were closed. The Department issued a finding of a violation of Chapter 440, F.S., in three of them. In two of the three cases, after obtaining an EMA opinion, the Department issued a notice of administrative action to the physicians, barring the physicians from future reimbursement under Chapter 440, F.S. and imposing a $5,000.00 penalty against each of them. In the remaining case, a notice was issued to the physician for failing to properly document in the medical records, the medical necessity of services rendered.

Six cases were closed without a finding of a violation. The Department determined the insurer either failed to substantiate the allegation with evidence-based medical literature or practice guidelines, or failed to properly review medical bills to disallow or adjust payment for treatment that constituted overutilization of services or other violations. The remaining two of the eleven cases processed are open cases, pending further investigation and possible referral to an EMA.

II. Resolution of Reimbursement Disputes

The Medical Services Section is also responsible for resolving medical reimbursement disputes between providers and payers. Reimbursement Disputes must be filed within 45 days from the provider's receipt of the carrier's notice of disallowance, denial or adjustment of payment. The following graphics provide an overview of the Medical Services Section's case load and the nature of the reimbursement dispute process and its outcomes.

A. The Medical Services Section received 10,483 Reimbursement Disputes during FY 2013-2014. **Graphic 1.1** illustrates the total number of Petitions for Resolution of Reimbursement Dispute submitted to the Medical Services Section during the last five fiscal years. The volume of Medical Reimbursement Disputes filed by Practitioners is significantly higher than other provider types due to disputes involving physician dispensed medication.

   The Medical Services Section closed a total of 10,425 petitions received prior to the current fiscal year. Out of the 10,425 petitions closed, 5,454 resulted in the issuance of Determinations while the remaining 4,971 resulted in dismissals as respectively seen in **Graphics1.2** and **1.3**.

1.1 Petitions Submitted by Provider Type by FY					
	09-10	**10-11**	**11-12**	**12-13**	**13-14**
Practitioner	296	1,308	12,718	7,819	8,483
ASC	373	655	687	737	665
Hospital Inpatient	330	436	332	350	266
Hospital Outpatient	1,071	1,378	1,273	1,303	1,069
Total	2,070	3,777	15,010	10,209	10,483

1.2 Petitions Determination Outcomes by Provider Type by FY					
	09-10	**10-11**	**11-12**	**12-13**	**13-14**
Practitioner	102	706	1,853	2,573	3,992
ASC	226	412	471	584	512
Hospital Inpatient	216	286	218	217	183
Hospital Outpatient	1,177	941	823	966	767
Total	1,721	2,345	3,365	4,340	5,454

1.3 Petitions Dismissal Outcomes by Provider Type by FY					
	09-10	**10-11**	**11-12**	**12-13**	**13-14**
Practitioner	221	478	1,647	2,605	4,432
ASC	125	219	157	216	173
Hospital Inpatient	112	133	109	140	96
Hospital Outpatient	298	411	346	448	270
Total	756	1,241	2,259	3,409	4,971

B. During Fiscal Year 2013-2014, the number of Reimbursement Disputes dismissed due to untimely filing decreased by 26% from 1,283 last year to 951, resulting in the Failure to Cure Deficiency as becoming the number one reason that Reimbursement Disputes were dismissed.

1.4 Petitions Dismissals Issued By Reason by FY					
	09-10	**10-11**	**11-12**	**12-13**	**13-14**
Failure to Cure Deficiency	237	507	547	617	998
Untimely Filed	230	255	930	1,283	951
Other Reason	15	19	28	41	88
Lack of Jurisdiction	45	92	131	191	202
Non-HCP	4	30	13	4	2
Managed Care	4	9	137	80	274
Not-Ripe for Resolution	20	34	32	25	8
Improper Service	0	0	0	0	0
Not Reported	0	0	4	1	0

C. The Medical Services Section discovered that the petitioner had been underpaid in 86% of all determinations issued for Fiscal Year 2013-2014**.** However, in most cases, the amount reimbursed to the provider rarely equaled the billed amount. Therefore, the amount found to be due was typically less than the billed charge.

1.5 Determinations Issued by Reason per FY					
	09-10	**10-11**	**11-12**	**12-13**	**13-14**
Under-Payment	1,635	2,181	3,095	3,871	4,699
Correct Payment	25	41	83	118	127
Over-Payment	34	28	75	96	97
Other Finding	2	5	3	10	16
No Additional Payment Due	26	90	109	244	515