Report to the Three-Member Panel

Regarding the Resolution of Medical Reimbursement Disputes and Actions

Pursuant to Subsection 440.13(12)(e), Florida Statutes

Fiscal Year 2015 - 2016

Florida Department of Financial Services
Division of Workers' Compensation
Medical Services Section
January 2017

Introduction and Overview

The Department of Financial Services (Department) is required 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 subsection 440.13(12)(e), Florida Statutes (F.S.).

The Medical Services Section administers four programs pursuant to section 440.13, F.S.: policy development and implementation of several health care provider 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) 2015-2016.

Report on Patterns or Practices of Overutilization for Health Care Providers (HCP)

The Department is granted authority, pursuant to the provisions in subsections 440.13(8) and (11), F.S., to investigate and evaluate a physician's billing and reporting practices to determine if he or she 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. This process is initiated by the review of paid medical claims data submitted to the Division by workers' compensation carriers or by complaints from industry stakeholders alleging violations of Chapter 440, F.S.

In 2011, the Department adopted Rule Chapter 69L-34, F.A.C., to establish the process by which carriers and other industry stakeholders could report alleged instances of overutilization of services. During the previous fiscal year, the Department introduced an on-line portal for the submission of referrals in a timelier and more efficient manner. The on-line process allows a complainant to create an electronic case file to report violations, including overutilization of services and to upload evidence based medical documentation to reasonably support an alleged violation.

During (FY) 2015-2016, the Department processed[1] seven violation referrals, filed by carriers or entities acting on behalf of a carrier, alleging a Standard of Care Violation[2] including overutilization of services.

[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 the carrier to substantiate the overutilization or other Standard of Care violations; or issuance of a finding of violation.

[2] A Standard of Care violation addresses the appropriateness of treatment for a compensable condition based on prevailing medical practices and treatment guidelines, which include the correctness of the coding of treatment and the sufficiency of medical records documenting the level, duration, frequency and intensity of billed services.

All of the referrals were received during this reporting period. Each of the seven cases processed were filed against medical doctors. All are licensed under the Florida Board of Medicine.

The specific violations cited in the seven referrals processed during FY 2015-2016 included:

- Failure to substantiate the medical necessity of the treatment rendered;
- Failure to substantiate the medical necessity of the frequency of the services rendered; and
- Failure to substantiate the medical necessity of the duration of the services rendered.

The seven cases were closed on the basis that the documentation did not substantiate a HCP over-utilization violation. Consequently, the Department did not require the use of an Expert Medical Advisor to issue its determination in these cases.

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 Medical Services Section received 5,526 reimbursement disputes during FY 2015-2016. The Medical Services Section closed a total of 18,103 petitions during the same period. Out of the 18,103 petitions closed, 9,570[3] resulted in the issuance of determinations and 8,533 resulted in dismissals.

Petitions Submitted by Provider Type and FY					
	11-12	**12-13**	**13-14**	**14-15**	**15-16**
Practitioner	12,460	7,805	8,412	7,323	3,601
ASC	687	737	665	331	400
Hospital Inpatient	332	350	266	453	341
Hospital Outpatient	1,273	1,303	1,069	1,550	1,184
Total	**14,752**	**10,195**	**10,412**	**9,657**	**5,526**

[3] This total incudes other findings not otherwise classified which are not reflected in the tables presented in this report.

Petition Determinations by Provider Type and FY					
	11-12	**12-13**	**13-14**	**14-15**	**15-16**
Practitioner	1,853	2,573	3,992	4,326	8,221
ASC	471	584	512	213	240
Hospital Inpatient	218	217	183	226	215
Hospital Outpatient	823	966	767	996	894
Total	**3,365**	**4,340**	**5,454**	**5,761**	**9,570**

Petitions Dismissed by Provider Type and FY					
	11-12	**12-13**	**13-14**	**14-15**	**15-16**
Practitioner	1,647	2,605	4,432	2,374	7,636
ASC	157	216	173	104	175
Hospital Inpatient	109	140	96	181	174
Hospital Outpatient	346	448	270	432	548
Total	**2,259**	**3,409**	**4,971**	**3,091**	**8,533**

For the previous two fiscal years, the most frequent reason for dismissal was the withdrawal of petitions. However, during Fiscal Year 2015-2016, the most frequent reason for dismissal was failure to file within statutory time requirements (untimely filed). The number of petitions withdrawn decreased by 29% from 1,469 in Fiscal Year 2014-2015 to 1,043 in Fiscal Year 2015-2016. The number of petitions dismissed due to untimely filing increased by 741% from 515 last year to 4,330. The number of petitions dismissed due to deficiencies (failure to cure deficiencies) in the documentation submitted to the Division, in support of the Petition for Resolution of Reimbursement Dispute, increased by 322% from 624 last year to 2,633.

Petitions Dismissed by Reason and FY					
	11-12	**12-13**	**13-14**	**14-15**	**15-16**
Petition Withdrawn	437	1,167	2,448	1,469	1,043
Failure to Cure Deficiency	547	617	998	624	2,633
Untimely Filed	930	1,283	951	515	4,330
Other Reason	28	41	88	231	235
Lack of Jurisdiction	131	191	202	228	254
Non-HCP	13	4	2	2	0
Managed Care	137	80	274	2	5
Not-Ripe for Resolution	32	25	8	22	19
Duplicate Petition	0	0	0	0	27

The Medical Services Section discovered that the HCP had been underpaid in 85.5% of all determinations issued for Fiscal Year 2015-2016. This discovery stems from the results of data analyses performed by the Medical Services Section to identify specific trends in medical billing and reporting. The amount of under-payment varied depending on the type of service in dispute. Additionally, the amount the Medical Services Section determined was due to the HCP did not always equal the amount billed.

Determinations Issued by Reason and FY					
	11-12	**12-13**	**13-14**	**14-15**	**15-16**
Under-Payment	3,095	3,871	4,699	5,286	8,189
Correct Payment	83	118	127	41	324
Over-Payment	75	96	97	44	72
No Additional Payment Due	109	244	515	387	957