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 2017 - 2018

Florida Department of Financial Services
Division of Workers' Compensation
Medical Services Section
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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 (EMA); 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) 2017-2018.

I. 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. The Department maintains an on-line portal for the submission of referrals in a more timely and 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 medical evidence-based documentation to reasonably support an alleged violation.

During FY 2017-2018, the Department processed[1] eleven violation referrals, filed by insurers or entities acting on behalf of the insurer alleging a Standard of Care Violation[2], including overutilization of services. Nine of the eleven cases processed were filed against medical doctors, and two were filed against licensed clinical social workers.

The violations cited in the eleven referrals processed during FY 2017-2018 included:

- Failure to substantiate the medical necessity of the treatment rendered;
- Failure to substantiate the medical necessity of the frequency of the services rendered;
- Collecting or receiving payment from an injured worker in violation of paragraph 440.13(13)(a), F.S.; and
- Improper reporting of services, failing to submit medical records and reports (DWC-25's) to the carrier.

Of these eleven cases, nine were related to failure to substantiate the medical necessity of the treatment rendered and/or failure to substantiate the medical necessity of the frequency and duration of services. These nine 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 EMA to issue its determination in these cases.

Of these eleven, one case involved improper reporting of services (failing to submit medical records and reports (DWC-25's) to the carrier). For this case, a documentation request letter was issued to the HCP and the HCP responded with proper documentation. Therefore, no further action was taken, and the case was closed.

The additional case involved collecting or receiving payment from an injured worker in violation of paragraph 440.13(13)(a), F.S. The Division dismissed this case since the carrier/entity for the carrier failed to provide supporting documentation pursuant to Rule 69L-34.003, F.A.C.

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.

During FY 2017- 2018, four million medical bills were filed with the Division, and of these four million medical bills, the Medical Services Section received 3,234 reimbursement disputes. The Medical Services Section closed a total of 3,912 petitions during the same period. Out of the 3,912 petitions closed, 1,717[3] resulted in the issuance of determinations and 2,195[3] resulted in dismissals.

Petitions Received by Provider Type During the FY					
	13-14	**14-15**	**15-16**	**16-17**	**17-18**
Practitioner	8,412	7,323	3,601	4,072	1,687
ASC	665	331	400	348	384
Hospital Inpatient	266	453	341	238	376
Hospital Outpatient	1,069	1,550	1,184	640	787
Total	**10,412**	**9,657**	**5,526**	**5,298**	**3,234***

* one provider type was unreported

Petition Determinations Issued by Provider Type During the FY					
	13-14	**14-15**	**15-16**	**16-17**	**17-18**
Practitioner	3,992	4,326	8,221	1,425	929
ASC	512	213	240	248	215
Hospital Inpatient	183	226	215	112	199
Hospital Outpatient	767	996	894	370	374
Total	**5,454**	**5,761**	**9,570**	**2,155**	**1,717**

Petition Dismissals Provider Type During the FY					
	13-14	**14-15**	**15-16**	**16-17**	**17-18**
Practitioner	4,432	2,374	7,636	2,067	1,507
ASC	173	104	175	123	145
Hospital Inpatient	96	181	174	110	169
Hospital Outpatient	270	432	548	270	374
Total	**4,971**	**3,091**	**8,533**	**2,570**	**2,195**

During FY 2017-2018, the most frequent reason for dismissal was related to the withdrawal of the petition, and the second most frequent reason was a failure to cure a deficiency.

Petitions Dismissals Issued by Reason During the FY					
	13-14	**14-15**	**15-16**	**16-17**	**17-18**
Lack of Authorization	NA	NA	NA	904	226
Petition Withdrawn	2,448	1,469	1,043	688	1,276
Failure to Cure Deficiency	998	624	2,633	478	309
Untimely Filed	951	515	4,330	183	146
Other Reason	88	231	235	129	99
Lack of Jurisdiction	202	228	254	117	76
Non-HCP	2	2	0	1	2
Managed Care	274	2	5	0	0
Not-Ripe for Resolution	8	22	19	27	19
Duplicate Petition	0	0	27	44	17
Billing Error	0	0	0	0	24
Settlement Agreement	0	0	0	0	1

The Medical Services Section discovered that the HCP had been underpaid in 89% of all determinations issued for FY 2017-2018**.** 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.

Petition Determinations Issued by Reason During the FY					
	13-14	**14-15**	**15-16**	**16-17**	**17-18**
Under-Payment	4,699	5,286	8,189	1,706	1,531
Correct Payment	127	41	324	35	49
Over-Payment	97	44	72	11	13
No Additional Payment Due	515	387	957	393	121

[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 EMA 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.

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