



Florida Department of Labor and Employment Security
Division of Workers' Compensation
Director's Office

Jeb Bush
Governor

Mary B. Hooks
Secretary

Charles Williams
Director

ALERT! ALERT! ALERT! ALERT! ALERT! ALERT!
BULLETIN

To: All Carriers, Self- Insurers, Third Party Administrators, Health Care Providers and Other Interested Parties

From: Charles Williams, Director

Date: Tuesday, January 25, 2000

Re: Medical – Rehabilitation Bulletin

The attached Bulletin contains information regarding medical and rehabilitation services provided under s.440.13, Florida Statutes.

Attachments

Bulletin No. 214

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**REHABILITATION – MEDICAL
BULLETIN**

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This bulletin includes information on the following topics:

<u>ITEM</u>	<u>TOPIC</u>
A.	Provider Reimbursement in Managed Care Arrangements
B.	Carrier Utilization Review
C.	Petition for Benefits Filed by Health Care Providers
D.	Delayed Medical Authorization – Requests for Assistance
E.	Clarification on Roles of Division and Agency for Health Care Administration
F.	Education and Technical Provided by Bureau of Rehabilitation and Medical Services

January 25, 2000

PROVIDER REIMBURSEMENT IN MANAGED CARE ARRANGEMENTS:

The 1993 amendments to workers' compensation law establish section 440.134, Florida Statutes (F.S.), workers' compensation managed care arrangements (WCMCAs). This section mandates that employers furnish medically necessary treatment and care to injured employees solely through WCMCAs offered by insurers. However, section 440.134, F.S., does not specifically address reimbursement to health care providers who provide medical services through managed care arrangements.

Statutorily charged with reimbursement determination responsibilities in section 440.13(12), F.S., the Governor's three member panel is responsible for adopting schedules of maximum reimbursement allowances. Moreover, section 440.13(12), F.S., is the only section of Chapter 440, F.S., that legislates reimbursement for workers' compensation medical services and supplies, whether the usual and customary charge, the agreed-upon contract price or the maximum reimbursement allowance (MRA) in the schedules provided for in this section. The law does not require an insurer to negotiate any health care provider payment based on the schedules approved by the panel for medical services provided through an insurer's WCMCA.

At this time there appears to be confusion in the industry that an insurer must use the 1997 Florida Workers' Compensation Health Care Provider Fee For Service Reimbursement Manual (1997 RM) as a benchmark when negotiating a contract for reimbursement with a health care provider. Many WCMCAs are currently utilizing the 1997 RM as the basic guide in contracting with health care providers although they are not required to do so. As a point of clarification, an insurer does not have to contract above, below or at the established maximum reimbursement allowance listed in the 1997 RM. When the terms of payment with a provider within a WCMCA are established by an insurer, the contracted levels of reimbursement may be provider specific or may be based on any national treatment standards and guidelines for authorization and reimbursement of medically necessary services. However, the contractual terms must be mutually accepted by both parties. For example, while the 1997 RM does not address payment for services not yet rendered or prepayment, when contractual arrangements are established between the provider and insurer, prepayment for specific services may be stipulated in the contract.

An insurer may utilize various medical resources in provider reimbursement contracting. The traditional workers' compensation cost containment policies and schedules of MRAs do not have to be adopted by an insurer. Another provider reimbursement option may be for an insurer to set up a capitated contract with a provider. An insurer may enter into such contracts only if the capitated amount for rendering covered medical services will be paid directly to the person who contracts with the insurer. A copy of the capitated contract, excluding the capitated amount, must be filed with the Agency for Health Care Administration for approval before implementation.

CAVEAT: Any treatment rendered by a provider outside a WCMCA must be reimbursed by an insurer according to the Division's promulgated schedule and reimbursement guidelines in effect.

CARRIER UTILIZATION REVIEW:

In many instances the division is finding that carriers are not properly managing their utilization review of cases. Where overutilization is identified, carriers are inappropriately reporting to the division rather than attempting to resolve issues through their internal utilization review process. When remedial treatment is rendered through a WCMCA, s.440.13 (8), F.S., allows carriers to refer instances of overutilization to the division for a determination of whether the health care provider (HCP) has engaged in a pattern or practice of inappropriate utilization or other specific regulatory violations under the workers' compensation law.

The division's interpretation of the carrier's responsibility under this citation is that a carrier should not report an individual HCP in its WCMCA provider network after each utilization review case finding. However, when the carrier has documentation that a HCP has utilized medical treatment inappropriately and has not responded to the corrective action interventions in the approved plan of operation, the carrier should include the same information presented to the HCP during the utilization review process including a copy of any independent medical evaluation when making a referral to the division. The referral should include documentation of appropriate interventions to correct the utilization problem as well as the final determination of any formal grievance filed by the HCP related to the case.

Carriers and their agents should not refer possible instances of overutilization to the division unless the utilization process has included a review by a physician to substantiate inappropriate service. Furthermore, the treating physician should be given timely, objective feedback regarding specific services for which the carrier has identified utilization concerns or the reason for the objection. Lastly, a credible utilization review process should allow the treating physician to address utilization questions or issues with a peer designated by the carrier according to the plan of operation. Referrals from carriers based solely on duration of care which has neither been properly substantiated by a peer nor specifically identified to the provider are not valid referrals of overutilization. In addition, when overutilization has been properly substantiated and the carrier has not taken timely corrective action or deauthorized the HCP, the division may determine that penalties against the HCP by the carrier are not appropriate. Both carriers and HCP's should be aware that the division may assess administrative fines against, or issue an order for repayment to either the carrier or HCP if it establishes a pattern or practice of inappropriate utilization review or improper reimbursement.

PETITION FOR BENEFITS FILED BY HEALTH CARE PROVIDERS:

Some Health Care Providers (HCP's) are inappropriately utilizing the Petition For Benefits (PFB) venue for resolving reimbursement and utilization disputes with carriers. When reimbursement or utilization disputes arise between carriers and HCP's, it is the exclusive jurisdiction of the division to resolve such disputes that arise subsequent to January 1, 1994. Under no circumstance should a HCP or carrier

attempt to resolve either dispute by filing a PFB for a hearing before a Judge of Compensation Claims (JCC). Any PFB filed by a HCP related to reimbursement or utilization issues is inappropriate and will be rejected by the division as improper.

When the remedial treatment in dispute between a HCP and carrier was rendered through a WCMCA, the division will only accept disputes in the following situations: (1) the reimbursement contract between carrier and the HCP must specify that reimbursement is according to the division's Reimbursement Schedule promulgated as a rule under the Florida Administrative Code. Reimbursement contracts which include alterations or modifications of the division's rule (including discounts or percentage or increases over the maximum reimbursement allowances) or which are based on selected provisions of the rule are not within the jurisdiction of the division.

(2) the petitioner provides the division with documentation that the dispute resolution provisions of s.440.134(6)(c), F.S., have been made available and exhausted by the HCP. Therefore, a carrier's plan of operation must include the provision of such documentation to the HCP and the dispute resolution process implemented under s.440.134, F.S., must inform the HCP of the right to petition the division within 30 days as required in s.440.13(7), F.S.

DELAYED MEDICAL AUTHORIZATION – REQUESTS FOR ASSISTANCE (RFA)

The division continues to receive inappropriate "medical authorization" Requests For Assistance (RFA) from injured employees subject to WCMCA's. Carriers must be cognizant that the authorization of medical treatment within a WCMCA is the responsibility of the physician Medical Care Coordinator (MCC) and not the adjuster. In cases where the division determines that medically necessary treatment within a WCMCA is delayed pending "authorization" by an adjuster or other inappropriate utilization review techniques, such a finding may establish a pattern of questionable claims handling by the carrier. Therefore, in instances where the adjuster questions a remedial service ordered by a HCP for the treatment or care of an injured employee, irrespective of whether the question arises from compensability or medical necessity, an adjuster may not delay the delivery of treatment or care authorized by the MCC. Inappropriate delays in treatment based solely on obtaining "authorization" from an adjuster may also constitute inappropriate denial of medical benefit to be resolved by the JCC.

ROLES OF THE DIVISION AND AGENCY FOR HEALTH CARE ADMINISTRATION:

All employers subject to the workers' compensation law must provide remedial medical treatment through a WCMCA for any injury sustained on or subsequent to January 1, 1997. The Division and the Agency for Health Care Administration (AHCA) share responsibility for the overall successful implementation of this 1997 WCMCA legislation. While AHCA has the direct frontline responsibility to insure that carriers provide access to remedial treatment under a WCMCA through adequate provider networks and appropriate plans of operation, the division has the responsibility to oversee all aspects of the benefit provision and carrier performance. It is the division's mission to ensure injured employees are treated fairly and to control cost for employers through a self-executing workers' compensation system. Because an efficient and effective delivery process for remedial treatment does affect the carrier's obligation to provide proper medical and disability benefits, the division's jurisdiction extends into scrutiny of an approved WCMCA plan of operation, whenever necessary. In contrast, ACHA's

scope of responsibility is limited to ensure that carriers have the infrastructure to promote a self-executing, cost effective process for delivering medically necessary remedial treatment.

EDUCATION/TECHNICAL ASSISTANCE: The division's Bureau of Rehabilitation and Medical Services staff is available to provide carriers with guidance, education and technical assistance with statutory requirements under the workers' compensation law. In situations where remedial treatment is not provided within a WCMCA, regardless of the date of injury, carriers and HCP's are subject to the provisions of s.440.13, F.S., exclusively. Therefore, carriers must comply with applicable rules concerning dispute resolution and utilization review as required by statute. In addition, the division's staff is available to provide guidance on the division's jurisdiction regarding the interrelationships between an approved WCMCA plan of operation and overall acceptable claims handling.

