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

Fiscal Year 2019 - 2020

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 paragraph 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) 2019-2020.

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 the health care providers' 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, improper billing, and billing errors. The Department maintains an online portal for the submission of referrals in a more timely and efficient manner. The online process allows a complainant to create an electronic case file to report violations and upload supportive documentation for each alleged violation.

During FY 2019-2020, the Department processed[1] 15 HCP violation referrals filed by insurers or entities acting on behalf of the insurer alleging a Standard of Care Violation[2], including overutilization of services. Of the 15 HCP cases processed, nine were filed against medical doctors (three of the nine were out-of-state providers), two were filed against Pharmacists, one was filed against a Chiropractor, and three were filed against hospitals.

The violations cited in the 15 HCP referrals processed during FY 2019-2020 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 billing and billing errors.

Further review of the 15 HCP cases found, six were related to allegations of failing to substantiate the medical necessity of the treatment rendered and/or failing to substantiate the medical necessity of the frequency and duration of services. Out of these six cases, five did not substantiate an alleged HCP over-utilization violation, and therefore were

closed; one HCP Violation Referral included supporting documentation of an overutilization of services pursuant to paragraph 440.13(8), F.S, and the Division utilized the services of an EMA and issued an Overutilization Determination in this case. However, the case was resolved as the Carrier and Health Care Provider reached a settlement.

Of the remaining cases, four were related to improper billing and billing errors and they were closed due to failure to substantiate the alleged violation, and five HCP cases involved collecting or receiving payment from an injured employee which constitutes a violation of paragraph 440.13(13)(a), F.S. Out of these five cases, three cases were resolved and closed after the Division issued HCP Violation Investigation letters, and two cases were closed due to the Complainant's failure to submit the supporting documentation pursuant to Rule 69L-34, 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 2019-2020, 3.6 million medical bills were filed with the Division, and of these 3.6 million medical bills, the Medical Services Section received 4,607 reimbursement disputes. The Medical Services Section closed a total of 4,087 petitions during the same period. Out of the 4,087[3] petitions closed, 1,357 resulted in the issuance of determinations and 2,730 resulted in dismissals.

Petitions Received by Provider Type During the FY					
	15-16	**16-17**	**17-18**	**18-19**	**19-20**
Practitioner	3,601	4,072	1,687	1,386	2,274
ASC	400	348	384	367	361
Hospital Inpatient	341	238	376	500	611
Hospital Outpatient	1,184	640	787	1,047	1,361
Total	**5,526**	**5,298**	**3,234***	**3,300**	**4,607**

*One provider type was unreported

Petition Determinations Issued by Provider Type During the FY					
	15-16	**16-17**	**17-18**	**18-19**	**19-20**
Practitioner	8,221	1,425	929	432	344
ASC	240	248	215	202	171
Hospital Inpatient	215	112	199	223	31
Hospital Outpatient	894	370	374	583	811
Total	**9,570**	**2,155**	**1,717**	**1,440**	**1,357**

Petition Dismissals Issued by Provider Type During the FY					
	15-16	**16-17**	**17-18**	**18-19**	**19-20**
Practitioner	7,636	2,067	1,507	393	1,977
ASC	175	123	145	179	160
Hospital Inpatient	174	110	169	204	123
Hospital Outpatient	548	270	374	388	466
Total	**8,533**	**2,570**	**2,195**	**1,164**	**2,726**

During FY 2019-2020, 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					
	15-16	**16-17**	**17-18**	**18-19**	**19-20**
Lack of Authorization	NA	904	226	2	2
Petition Withdrawn	1,043	688	1,276	487	2,030
Failure to Cure Deficiency	2,633	478	309	420	322
Untimely Filed	4,330	183	146	128	186
Other Reason	235	129	99	31	4
Lack of Jurisdiction	254	117	76	83	56
Non-HCP	0	1	2	0	0
Managed Care	5	0	0	0	0
Not Ripe for Resolution	19	27	19	5	112
Duplicate Petition	27	44	17	8	18
Billing Error	0	0	24	0	0
Settlement Agreement	0	0	1	0	0
Total	**8,546**	**2,571**	**2,195**	**1,164**	**2,730**

The Medical Services Section discovered that the HCP had been underpaid in 82% of all determinations issued for FY 2019-2020**.** 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 FY					
	15-16	16-17	17-18	18-19	19-20
Under-Payment	8,189	1,706	1,531	1,198	1,113
Correct Payment	324	35	49	73	28
Over-Payment	72	11	13	6	0
No Additional Payment Due	957	393	121	160	214

[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 includes other findings not otherwise classified which are not reflected in the tables presented in this report.