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Report to the Three-Member-Panel Regarding the Resolution of Medical Reimbursement Disputes pursuant to paragraph 440.13(12)(e), Florida Statutes

Fiscal Year 2021 - 2022

Florida Department of Financial Services
Division of Workers' Compensation
Medical Services Section
November 2022

Introduction and Overview

The Department of Financial Services (Department) is required to produce an annual report to the Three-Member Panel summarizing 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 on whether any health care provider has engaged in a pattern or practice of overutilization or in violation of the Workers' Compensation Laws or administrative rules; and the resolution of medical reimbursement and utilization disputes relating to medical treatment and services. This report will highlight the activities within the latter two programs during Fiscal Year (FY) 2021-2022.

Report on Patterns or Practices of Overutilization for Health Care Providers

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 a 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.

In 2011, the Department adopted Rule Chapter 69L-34, Florida Administrative Code (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. The online process allows a complainant to create an electronic case file to report violations and upload supportive documentation for each alleged violation in a more timely and efficient manner.

During FY 2021-2022, the Department processed 12 Health Care Provider violation referrals filed by carriers or entities acting on behalf of the carrier. Of the 12 Health Care Provider violation referrals processed, six were filed against physicians, one was filed against a hospital, and five were filed against chiropractors.

The violations cited in the 12 Health Care Providers violation referrals processed during FY 2021-2022 included:

- Failure to substantiate the medical necessity of the treatment rendered.
- Failure to substantiate the medical necessity of the frequency of the services rendered.
- Failure to submit medical records and reports pursuant to sections 440.13(4)(a) and (c), F.S.
- Improper billing, billing error violation, or otherwise failing to comply with billing and reporting requirements of Rules 69L-7.710, F.A.C., Rule 69L-7.730 F.A.C., and the applicable reimbursement manuals; and
- Collecting or receiving payment from an injured worker in violation of paragraph 440.13(13)(a), F.S.

Of these 12 Health Care Provider violation referrals:

- Six cases were closed based on failure to substantiate the alleged Health Care Provider's violation pursuant to 440.13(8), F.S.
- Two were related to improper billing and billing errors of services, and were closed as the complainants failed to submit supporting documentation pursuant to Rule 69L-34, F.A.C.
- Three alleged collecting or receiving payment from an injured worker and after investigation by the Division, these three were resolved.
- One alleged failure to submit medical records and reports to the carrier and after the Division contacted the Health Care Provider, the records were obtained. Thus, no further action was required.

Resolution of Reimbursement Disputes

The Medical Services Section is also responsible for resolving medical reimbursement disputes between health care providers and carriers. The reimbursement disputes must be filed within 45 days from the health care provider's receipt of the notice of disallowance or adjustment of payment.

During FY 2021-2022, 3.4 million medical bills were filed with the Division and, of these 3.4 million medical bills, the Medical Services Section received 7,241 reimbursement disputes. Additionally, the Medical Services Section closed a total of 4,710 petitions during the same period. Out of the 4,710 petitions closed, 1,892 resulted in the issuance of determinations, and 2,818 resulted in dismissals.

Petitions Received by Provider Type During the FY					
	17-18	**18-19**	**19-20**	**20-21**	**21-22**
Practitioner	1,687	1,386	2,274	4,412	4,547
Hospital Outpatient	787	1,047	1,361	983	1.339
Hospital Inpatient	376	500	611	794	1,033
ASC	384	367	361	322	322
Total	**3,234**	**3,300**	**4,607**	**6,511**	**7,241**

Petition Determinations Issued by Provider Type During the FY					
	17-18	**18-19**	**19-20**	**20-21**	**21-22**
Practitioner	929	432	344	1,791	1,222
Hospital Outpatient	374	583	811	450	478
ASC	215	202	171	163	181
Hospital Inpatient	199	223	31	17	11
Total	**1,717**	**1,440**	**1,357**	**2,421**	**1,892**

Petition Dismissals Issued by Provider Type During the FY					
	17-18	**18-19**	**19-20**	**20-21**	**21-22**
Practitioner	1,507	393	1,977	1,343	2,177
Hospital Outpatient	374	388	466	357	334
Hospital Inpatient	169	204	123	189	185
ASC	145	179	160	122	122
Total	**2,195**	**1,164**	**2,726**	**2,011**	**2,818**

During FY 2021-2022, the primary reason for the issuance of a dismissal was related to the voluntary withdrawal of the petition by the petitioner.

Petitions Dismissals Issued by Reason During the FY					
	17-18	**18-19**	**19-20**	**20-21**	**21-22**
Petition Withdrawn	1,276	487	2,030	1,322	2,331
Failure to Cure Deficiency	309	420	322	351	304
Untimely Filed	146	128	186	233	105
Lack of Jurisdiction	76	83	56	47	60
Duplicate Petition	17	8	18	27	17
Not Ripe for Resolution	19	5	112	26	1
Non-HCP	2	0	0	1	0
Managed Care	0	0	0	0	0
Lack of Authorization	226	2	2	1	0
Settlement Agreement	1	0	0	0	0
Other Reason	99	31	4	3	0
Billing Error	24	0	0	0	0
Total	**2,195**	**1,164**	**2,730**	**2,011**	**2,818**

During FY 2021 – 2022, the Division found that the petitions submitted by physicians had been underpaid in 75% of all determinations issued. This was a six percent decrease from the previous fiscal year**.**

Petition Determinations Issued by Reason During the FY					
	17-18	**18-19**	**19-20**	**20-21**	**21-22**
Under-Payment	1,531	1,198	1,113	2,292	1,734
Over-Payment	13	6	0	1	0
Correct Payment	49	73	28	24	17
No Additional Payment Due	121	160	214	104	137