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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 2020 - 2021

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 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 of whether any health care provider has engaged in a pattern or practice of overutilization or are in 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) 2020-2021.

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 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. 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 2020-2021, the Department processed eight HCP violation referrals filed by insurers or entities acting on behalf of the insurer. Of the eight HCP referrals processed, four were filed against medical doctors, three were filed against hospitals, and one was filed against a Physician Assistant.

The violations cited in the eight HCP referrals processed during FY 2020-2021 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.;
- Failure to refund an overpayment of reimbursement, pursuant to section 440.13(11)(a), F.S.; and
- Collecting or receiving payment from an injured worker in violation of paragraph 440.13(13)(a), F.S.

Further review of the eight HCP referrals found, one alleged failure to substantiate the medical necessity of the treatment rendered and the frequency of services to the injured worker. The case was closed as the Complainant failed to substantiate the alleged HCP violation pursuant to 440.13(8), F.S. Consequently, the Division did not utilize an expert medical advisor (EMA) to issue a decision in this case.

Furthermore, two referrals of the eight HCPs alleged failure to submit medical records and reports (DWC-25's). The Division reached out to the HCPs and the HCPs responded with the proper documentation. No further action was taken.

Of the remaining six cases, one referral alleged failure to refund an overpayment of reimbursement, pursuant to section 440.13(11)(a), F.S. and was closed as the complainant failed to substantiate the alleged violation, and four HCP referrals involved collecting or receiving payment from an injured worker. These cases were closed as the complainants failed to submit 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, adjustment of payment, or payment.

During FY 2020-2021, 3.4 million medical bills were filed with the Division and, of these 3.4 million medical bills, the Medical Services Section received 6,511 reimbursement disputes. The Medical Services Section closed a total of 4,432 petitions during the same period. Out of the 4,432 petitions closed, 2,421 resulted in the issuance of determinations, and 2,011 resulted in dismissals.

Petitions Received by Provider Type During the FY					
	16-17	**17-18**	**18-19**	**19-20**	**20-21**
Practitioner	4,072	1,687	1,386	2,274	4,412
ASC	348	384	367	361	322
Hospital Inpatient	238	376	500	611	794
Hospital Outpatient	640	787	1,047	1,361	983
Total	**5,298**	**3,234**	**3,300**	**4,607**	**6,511**

Petition Determinations Issued by Provider Type During the FY					
	16-17	**17-18**	**18-19**	**19-20**	**20-21**
Practitioner	1,425	929	432	344	1,791
ASC	248	215	202	171	163
Hospital Inpatient	112	199	223	31	17
Hospital Outpatient	370	374	583	811	450
Total	**2,155**	**1,717**	**1,440**	**1,357**	**2,421**

Petition Dismissals Issued by Provider Type During the FY					
	16-17	**17-18**	**18-19**	**19-20**	**20-21**
Practitioner	2,067	1,507	393	1,977	1,343
ASC	123	145	179	160	122
Hospital Inpatient	110	169	204	123	189
Hospital Outpatient	270	374	388	466	357
Total	**2,570**	**2,195**	**1,164**	**2,726**	**2,011**

During FY 2020-2021, the most frequent reason for dismissal was related to the voluntary withdrawal of the petition by the petitioner. The second most frequent reason was failure to cure a deficiency.

Petitions Dismissals Issued by Reason During the FY					
	16-17	**17-18**	**18-19**	**19-20**	**20-21**
Lack of Authorization	904	226	2	2	1
Petition Withdrawn	688	1,276	487	2,030	1,322
Failure to Cure Deficiency	478	309	420	322	351
Untimely Filed	183	146	128	186	233
Other Reason	129	99	31	4	3
Lack of Jurisdiction	117	76	83	56	47
Non-HCP	1	2	0	0	1
Managed Care	0	0	0	0	0
Not Ripe for Resolution	27	19	5	112	26
Duplicate Petition	44	17	8	18	27
Billing Error	0	24	0	0	0
Settlement Agreement	0	1	0	0	0
Total	**2,571**	**2,195**	**1,164**	**2,730**	**2,011**

As shown in the chart below, the HCP had been underpaid in 81% of all determinations issued for FY 2020-2021, this is a decrease from FY 2019-2020**.** The amount of under-payment varied, depending on the type of service in dispute. Additionally, the amount that 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					
	16-17	**17-18**	**18-19**	**19-20**	**20-21**
Under-Payment	1,706	1,531	1,198	1,113	2,292
Correct Payment	35	49	73	28	24
Over-Payment	11	13	6	0	1
No Additional Payment Due	393	121	160	214	104