Three-Member Panel Biennial Report

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Introduction and Background Discussion	Page 3
Survey of Stakeholders – Present Market	Page 6
Discussion of Key Issues	Page 7
Timing	Page 7
Education and Compliance	Page 7
Regulatory Organization	Page 8
Major Statutory Responsibilities	Page 12
Dispute Resolution	Page 15
Conclusions and Recommendations	Page 15

* Section 440.12(e)4, Florida Statutes, requires that the Three-Member Panel biennially submit recommendations to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation healthcare delivery system.

Introduction and Background Discussion

The Legislature enacted Senate Bill 108 in 2002, including a specific charge to the Three-Member Panel, Section 440.13(12)(e), Florida Statutes, to assess the adequacy of medical reimbursement, access, and other aspects of the health care delivery system in Workers' Compensation.

Charged with that objective, CFO Gallagher and the members of the Three-Member Panel engaged a consultant, who, with the cooperation of both the Workers' Compensation Medical Services Unit of the Agency for Health Care Administration (AHCA) and the Division of Workers' Compensation (DWC), performed a detailed analysis of the issues and challenges to the Workers' Compensation health care delivery system. The following issues were identified as result of the investigation:

- Medical reimbursement was inadequate for many services and procedures.
- Access to quality health care providers was diminished.
- Over-utilization of medical services and procedures occurred, as did an excessive use of second opinions, IME's, transfers-of-care, and other means of "doctor shopping."
- Excessive amounts of and wide variations in paperwork and bureaucracy impeded medical care and communication.
- Wide variation in medical practice and behavior produced conflicts and disputes regarding case decision-making such as authorization for services, return to work, and assignment of benefits.
- Wide variation in carrier, network, case management, and employer practices, process, and criteria resulted in a difficult, time-consuming and costly interface for health care providers.
- Excessive disputes and litigation occurred over medically related issues due to poor consensus of criteria for decision-making and determinations.
- Ultimately, this resulted in dramatically poor results system wide, including poor medical outcomes and return-to-work, excessive disability and impairment, excessive litigation, and prohibitively high overall Workers' Compensation costs.

Based on those conclusions, a comprehensive, integrated reform proposal was developed and submitted to the Three-Member Panel, who in turn endorsed it unanimously. The plan had four (4) principal content categories and two (2) process categories of recommendations:

1. Operationally define key <u>medically</u> related terms, services, criteria, expectations, as well as roles & responsibilities that are the centerpiece for the system as a whole.
2. Establish a fair and stable medical <u>reimbursement</u> system for both health care providers and hospitals that is the same for comparable services regardless of venue, and is adjusted using the medical price index (MPI).
3. Establish an expedited <u>dispute resolution</u> system that would tighten the definition of a dispute, require evidentiary pleading, establish a unified operation for claims management, and separate medical from administrative-legal issues.
4. Regarding <u>work status and indemnity benefit</u>, shift from an impairment (illness) based model to a disability (function and vocational/economic impact) model, thereby enhancing decisions and outcomes by utilizing more relevant factors.

❖ In general, use streamline processes and single, uniform, documentation; replace antiquated, redundant and/or excessively divergent regulatory or industry efforts.

❖ Collect and maintain well-defined, relevant process data and outcome statistics to properly assess and continually, but thoughtfully, enhance the system over time.

Shortly thereafter, Governor Bush established the Commission on Workers' Compensation Reform which had a similar but broader charge; to look at all aspects of the system, including availability of insurance coverage, and the controversial issues of exemptions and attorney fees. The Commission held numerous hearings throughout the state, and allowed all parties to provide information, feedback, and recommendations. The Three-Member Panel worked closely with the Commission throughout their process. Ultimately, after exhaustive testimony, research and consideration, the Commission voted to utilize the Three-Member Panel's final report as the basis for their final report and recommendations.

The plan was submitted to the Legislature in January 2003 for their consideration on behalf of both the Three-Member Panel and The Governor's Commission. The Legislature held committee hearings in both the House and the Senate. Ultimately, a Workers' Compensation reform bill was passed (SB50A) during the first special session of the 2003 Legislature, a combination of reform efforts and recommendations from various stakeholder groups.

The following are select medically related highlights from SB 50A:

- Provided specific definitions and criteria for medical issues such as compensability, major contributing cause, mental and nervous conditions, as well as standards of care to be used in determining authorization for services, assignment of benefits, and return to work. Most importantly, it mandated that all case decisions, determinations, and management be scientifically logical, and based on objective relevant findings, including providing specific criteria to meet that standard.
- Mandated the use of specific medical practice parameters.
- Established criteria, terms and conditions defining and limiting transfers of care, independent medical exams (IME), court-appointed expert medical advisors (EMA), and a new option called *consensus* IME.
- Emphasized the focus on functional restoration and return-to-work, including clarifying the role of the physician and other relevant health care providers in providing appropriate limitations and restrictions to be used by the employer in facilitating work modifications and progressive transition to regular duty status.
- Required health care providers to use a *sports medicine* approach emphasizing function, aggressive follow-up and progression, and that the functional limitations/restrictions not be presumed or based on nondescript diagnostic labels, but rather correlated to the injured worker's specific clinical and physiologic dysfunction via the objective relevant medical findings.
- Raised maximum reimbursement allowances (MRA) for select physicians, medical physicians (MD) and osteopathic physicians (DO), while attempting to lower hospital payments by lowering the percentage of charges paid for out-patient services and putting controls on prescription medication.
- Attempted to stabilize reimbursement rates by utilizing the Medicare Resource-Based Relative Value Scale (RBRVS) format and tying the MRA's to a percentage of Medicare.
- Provided that physical, occupational and speech therapy, as well as clinical laboratory and radiology shall have the same MRA's regardless of venue (hospital vs. non-hospital).
- Provided for favorable deviations from the fee schedule for health care providers that pre-agree to certain quality care standards and practices.

In addition, there were substantive provisions addressing exemption waivers and other coverage issues, limitations on attorneys fees, changes in the dispute resolution/litigation process, changes in indemnity benefits (especially criteria for PTD), more stringent regulatory provisions regarding compliance,

access to medical records and information, changes and clarification regarding WCMCA's, carrier practices, and changes to the WCJUA.

Governor Bush signed SB 50A on July 15, 2003 activating a few of the provisions immediately. The majority of the provisions became effective October 1, 2003 and the remaining provisions on January 1, 2004.

Once the bill was signed, associated rule development and promulgation began. Two specific rules are particularly noteworthy with respect to the health care delivery system and the new legislation:

- The Billing Rule required:
  - Carrier compliance with timely and appropriate provider reimbursement and EDI submission requirements to the Division.
  - The development and promulgation of the Florida Workers' Compensation Universal Medical Treatment / Status Form (DWC-25).
- The Reimbursement Manual rule changes required:
  - Clarifications in the introductory or rule sections of the Health Care Provider (HCP) Reimbursement Manual.
  - Changes in maximum reimbursement allowances (MRA) in the HCP, Hospital, and Ambulatory Surgical Center (ASC) manuals.

Also as part of rulemaking, the Three-Member Panel (in coordination with the Agency for HealthCare Administration (AHCA) and the Division of Workers' Compensation (DWC)) updated the Reimbursement Manuals on several occasions in recent years:

- 2001 HCP Reimbursement Manual was an overall increase of 2.7% (effective 9-30-01).
- 2002 HCP Reimbursement Manual was an overall increase of 3.4% (effective 7/7/2002).
- 2003 HCP Reimbursement Manual was an overall increase of 1.6% (effective 12/3/2003).
- 2004 HCP Reimbursement Manual (effective 1/1/2004).
  - Medical and Osteopathic physicians received an increase equal to 110% of Medicare for non-surgical procedures and services.
  - For surgical procedures the MRA was increased to 140% of Medicare.
  - The reimbursement for all other HCP's stayed at the 2003 HCP Reimbursement Manual level.
  - Legislation passed in 2003 resulted in increases to physicians licensed under Chapter 458 and 459 (medical and osteopathic physicians). Therefore the above manuals were promulgated.
- 2004 HCP Reimbursement Manual, 2nd Edition (effective 7/4/2004).
  - Due to an increase enacted by Medicare after the effective date of the HCP Reimbursement Manual 2004, it was necessary to recalculate the reimbursements for medical physicians and osteopathic physicians.
- The following recommendations were made in reference to the 2005 HCP Manual during the 11/19/04 Three-Member Panel meeting:
  - Raise the Physical, Occupational and Speech therapists' reimbursement levels, as well as the reimbursement levels of Chiropractors and Podiatrists up to par with the 110% - 140% of Medicare model consistent with MD's and DO's.
  - Raise reimbursement for Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP) to 85% of the 110-140% as indicated.
  - Reduce Hospital reimbursement for implants to cost plus 20%, under some circumstances.

- Based on the average rule promulgation process, these changes will not go into effect until February 2005 at the earliest.

Survey of Stakeholders

In preparation for this report, a series of interviews were performed with a representative sample of carriers, health care providers, nurse case managers, employers, attorneys, Judges of Compensation Claims, NCCI, and regulators from DFS, AHCA, and DWC. The interviewees were asked to measure the difference in the workers' compensation health care delivery system since the new law and regulations were enacted. Additionally they were asked for their observations regarding more specific issues such as access and availability to quality providers and services, experience with the fee schedule and reimbursement, patterns of medical utilization, trends with grievances and disputes, ability to get useful and timely information, and work-related outcomes such as lost time, use of modified duty and transitional work, return-to-work, residual impairment and disability.

There were several issues where the interviewees expressed variance. The variances stem from several factors. Geographical considerations continue to be a major factor, with the panhandle, the Keys, and select rural areas reported as difficult to penetrate with substantive change. More recently, less traditionally difficult areas have become problematic. Communities like Jacksonville and Lakeland, where a single medical provider organization essentially dominates the market, creates a lack of competition and a challenge to the statutory and regulatory requirements. Other causes of variance is the degree to which providers, carriers, employers and the like are familiar with the new statute and rules and have begun to integrate them into their decision-making and work flow. Where there is familiarity, interviewees acknowledge seeing preliminary signs of improvement, especially in provider access and availability, as well as an apparent decrease in grievances and disputes on newer cases. Also, the medical criteria in the statute and rules are clearly helping workers' compensation customers (carriers, case managers, self-insured employers, even lawyers and judges) to be more judicious and to make better and faster decisions by knowing what to ask for, when to authorize it, and when to deny such claims. These efficiencies are compromised as many customers are either unaware of these changes in medical criteria, are unable to understand them, or cannot get the appropriate information from the health care providers.

There was consensus on a number of issues. Some of these issues were beneficial to the delivery system and others were problematic. The change of physician (transfer of care) and the independent medical examination (IME) process has apparently become less contentious as there are greater limitations so parties are more thoughtful on its use and less likely to abuse it. However, of great concern is the trend toward excessive charges for IME's as well as the imposition of logistical demands such as requiring the prepayment for service prior to considering the case.
A number of respondents noted specific provisions that they are very positive about, but have yet to fully utilize. For example, defined medical criteria or confining the physician's role to providing functional limitations/restrictions, leaving employment the domain of the employer and the actual terms of duty status to what the employer and employee can work out given that information.

There were several key points to which all interviewees were in agreement:

1. It is too early to determine the effectiveness of the reform efforts.
2. There is a need for a more comprehensive education program covering the new medically related statutory and regulatory provisions.

3. Enforcement of the statutory provisions with respect to medical service, reporting, and billing to ensure healthcare provider compliance is a critical element of the workers' compensation system.
4. The attorneys have adopted a "wait and see" attitude regarding filing or working new cases and are shifting their efforts to working the pre 10-1-03 cases.
5. The creation of a single regulatory entity and framework would enable the regulating agency to be more efficient, offer more comprehensive services, and eliminate the possibility of oversight gaps.

Discussion of Key Issues

Timing

It is a long held axiom that the bulk of the payout of any workers' compensation account occurs between years 3 and 5, as that is when the costliest cases are closed. In addition, there are significant time frame considerations in the dispute resolution system. Therefore, cases disputed today, will not be resolved for a year or more.

In addition, the National Council on Compensation Insurance (NCCI) notes that the claims detail or "unit statistical data" is not reported for 2-3 years; therefore, there is no way to assess the impact of reform during that period or longer. Current data is "aggregate" or generalized totals, which is sufficient for ratemaking, but insufficient for detailed analysis. The 14% rate reduction in October 2003 was in anticipation of the reform effort and subsequent improvement in the system as a whole and did not reflect the reimbursement increase noted in s. 440.13(12)(b), Florida Statutes. The -1% requested rate decrease, and the -5.2% decrease ordered by the Office of Insurance Regulation were also based on pre-reform data. The next filing is planned for the summer of 2005, with an effective date of 1-1-06. It is anticipated that NCCI will have only preliminary reform data included in its deliberations. NCCI notes that, although improved, Florida still ranks among the highest rates in the country so there is still more to be done, just not at this time. We need to see the impact the workers' compensation reforms have had to date. It generally takes several years of data compilation to determine patterns regarding the impact of any workers' compensation reform.

Education and Compliance

Senate Bill 50A and the rules implementing the bill reflect substantive and procedural changes that required extensive re-evaluation of the relative roles of the stakeholders and the regulatory agencies as to their responsibilities, evaluation criteria and processes. Less obvious, but maybe far more significant reform changes occurred in the medical portion of the statute and regulations. Significant definitions and criteria were altered in the most substantive way in many years. Senate Bill 50A fundamentally changed the way medical determinations and decisions are made.

However, some of the participants in the workers' compensation industry and stakeholder community have not utilized all of the tools now available in the workers' compensation system and therefore may hot have met all of the statutory and regulatory requirements. Practice parameters, managed care, provider networks and provider choice, fee schedules, return to work requirements, medical documentation and communication, impairment ratings, to name a few, have long been considered areas for significant variance and potential for abuse.

The 2002 Three-Member Panel Report contained a study that included a survey of the provider community addressing their issues and obstacles in providing services in the Workers' Compensation healthcare delivery system. Inadequate reimbursement was identified as the single most important obstacle to providing medical services in the Workers' Compensation system. The next most significant obstacle was the volume and the complexity of the paperwork documentation and communication requirements.

The medical billing rule created the Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form (DFS-F5-DWC-25), hereinafter referred to as the DWC-25. This form created a universal communication tool among the healthcare provider, insurer, and employer. This rule combined two DWC medical reporting forms into one and also eliminated other market-generated correspondence, forms and requests. The Three-Member Panel requested the relevant agencies develop and implement this single report format. The market survey and other input from stakeholders suggest that there are divergent interpretations of the various statutory provisions, associated rules, and that the DWC-25 would be more effective if it were more user friendly and streamlined.

The DWC, in consultation with the WC Medical Services Unit, consultants, and stakeholders recently redesigned the DWC 25, which is in the process of being adopted by rule, and expected to be implemented during the first quarter of 2005.

If all of the medically related functions were combined in the Division, a comprehensive educational program could be developed and implemented that would address medically-related statutory and regulatory requirements and provisions, especially medical and functional related issues and the DWC 25 form. In that respect, the coursework could include definitions of the various fields on the DWC 25 form, when and how the form is to be used, the benefits and value of using the form, the consequences for non-compliance, etc. Once education has been provided, then the same tracking and compliance measures that are being so effectively instituted regarding other provisions needs to be implemented regarding health care providers.

Regulatory Organization

Statutory provisions in Section 440.13, Florida Statutes, identify two different agencies to fulfill the provisions of Section 440.13, Florida Statutes, causing some inefficiencies. Some are structural in nature, while others are a matter of divergent priorities and management issues. Examples of each of the two categories of issues (structural, management) are offered below:

- Section 440.13(12)(e), Florida Statutes, states that the "Division is to provide administrative support and service to the panel to the extent requested by the panel." As a result, the AHCA WC medical staff has been involved at the specific request of the CFO, the Three-Member Panel and the Division. This is not the most efficient use of the WC medical staff given the travel time and other logistical issues which can arise due to the locations of the respective offices.

- Even though it is well established in the workers' compensation arena that "medical drives benefits," since the medical expertise is located within AHCA and not at the Division, there seems to be an integral piece of the workers' compensation system which should be consolidated with the rest of the support, oversight, analysis and compliance system.

- Since statutory requirements have two agencies involved in the implementation of Section 440.13, Florida Statutes, there could be inconsistent information being distributed to stakeholders, employers, and employees. The workers' compensation system needs all stakeholders to be held to a consistent standard of compliance and accountability, and therefore, there is a need to assure that the performance of healthcare providers is in compliance with the statutes and rules.

The following are examples of the challenges of the current regulatory framework:

- Due to limited Information Technology (IT) resources at AHCA, as is true of most state agencies, when the AHCA Workers' Compensation Medical Services Unit requested assistance with programming, IT maintenance, and technical assistance needed to access current medical data residing at the DWC, those requests are not always able to be fulfilled when requested.

- AHCA has maintained the health care provider (HCP) and Expert Medical Advisor (EMA) certification databases since the WC Medical Services Unit was transferred from DWC to AHCA. However, since the transfer external customers are no longer able to download the entire HCP and EMA databases from the AHCA website. The carriers are only able to verify individual providers causing operational inefficiencies for insurers who routinely downloaded the files to ensure that they were authorizing certified providers. There are several improvements needed that would provide better query capabilities for the customers. Upgrading the screens would provide better customer service and reduce the amount of assistance required from AHCA Workers' Compensation medical staff, freeing up this valuable resource for other necessary tasks.

- Having the Workers' Compensation Medical Services Unit located within DWC would facilitate the ability to efficiently provide the necessary clinical expertise on analyzing and interpreting issues, developing policy and procedures, and other relevant activity.

Senate Bill 50A created new statutory requirements for medical bill reimbursement and insurer performance standards for timely disposition of medical bills. For example,

- Section 440.20(2)(b), Florida Statutes, requires that insurers pay, disallow, or deny all medical bills within 45 calendar days of receipt.

- Section 440.20(6)(b), Florida Statutes, requires insurers to maintain a minimum 95 percent performance standard when processing medical bills for payment, disallowance, or denial in order to avoid penalties.
  - For each bill below a 95 percent performance standard but above a 90 percent performance standard, an administrative penalty of 25 dollars will be assessed.
  - For each bill below a 90 percent performance standard, an administrative penalty of 50 dollars will be assessed.

In response to this new legislation, DWC promulgated the Workers' Compensation Medical Billing, Filing, and Reporting Rule, 69L-7.602 F.A.C. This rule, which became effective 07/04/2004, requires insurers to report the disposition of all medical bills (provider, pharmacy, hospital and dental) to DWC in electronic format according to a staggered phase-in schedule; provides the technical aspects for data collection from insurers; and sets administrative penalties for untimely medical bill reporting to DWC. All insurers, self-insurers, and vendors are to be reporting all medical data electronically by March of

2005. This rule is significant in that it provides the Division with framework to monitor the disposition results of all medical bills to determine if insurers are in compliance with statutory requirements. The Division's new automated Medical Data System will soon be able to routinely monitor 100% of the 5 million medical bills submitted annually.

The receipt of all medical bill data electronically will create an opportunity to analyze and assess trends and conditions of relevant medical data enabling Workers' Compensation Medical staff to perform a more meaningful oversight of the workers' compensation medical care delivery system.

Some preliminary information with regard to medical performance from insurers illustrates the point:

- Over 400 insurers/self-insurers' reported all of their medical bills to the Division electronically in November of 2004. DWC systems electronically assessed, in a real time environment, all of these medical bills to determine compliance with the 95% payment standard. Of the four hundred insurers/self-insurers reporting electronically, only six (6) insurers/self-insurers were identified as failing to comply with the 95% standard. Penalty assessments were nominal.

- In comparison, in 2003, fewer insurers were reporting their medical bill data to the Division electronically. In December of 2003, the DWC reviewed the data that had been electronically submitted and assessed it based on a 95% standard. The Division found that of the 428 insurers self-insurers that had submitted their medical provider data (DWC-9) electronically, 68 insurers/self-insurers were below the 95% standard. The penalties would have been approximately $150,000 for that one month's performance.

- The ability to accurately measure performance against a well-defined standard, combined with a management decision to share the information as a form of education and positive incentive (combined with the ability and commitment to levy fines when appropriate) can measurably change insurer behavior to the desired level.

This past year the Division also worked with the carrier community to develop a new claims rule (Rule 69L-3, F.A.C.). The Division began rewriting this rule when SB 50A was signed into law in July 2003. The Division plans to implement this rule on or about January 1, 2005. This rule is the regulatory foundation for requiring indemnity benefits to be paid timely and accurately. This rule also establishes many of the Division's reporting requirements for the indemnity portion of the claim.

It is important to understand the statutory and regulatory provisions in regard to the current AHCA WC Medical Services Unit framework:

The duties and responsibilities of the Nurses and other specialized professional staff include:
- Certification of Health Care Providers;
- Certification of Expert Medical Providers;
- Ensuring the integrity of the Health Care Provider and Expert Medical Advisor databases;
- Responding to external customer telephone calls and e-mails providing programmatic expertise regarding policies, rules and regulations;
- Developing and implementing administrative rules pertaining to Section 440.13, Florida Statutes;
- Investigating and resolving complaints about providers, i.e., billing patient, refusing to produce medical records, refusing to provide MMI and PIR, non-compliance with administrative rules, etc.;

- Analyzing medical data in preparation for medical reimbursement manual updates;
- Preparing recommendations for the Three Member Panel and DFS concerning medical reimbursement policies and methodologies for inclusion in the reimbursement manuals;
- Resolving medical reimbursement disputes;
- Investigating complaints concerning utilization of remedial medical services or utilization control methods of a carrier;
- Implementation of a review process and special investigation process for evaluating provider compliance with established statutes and rules; and
- Participation in the identification of Workers' Compensation Medical Services Unit's key processes and business drivers; development of performance indicators and measures; and analyzing proposed legislation and administrative rules related to medical workers' compensation.

The duties and responsibilities of the professional support staff include:

- Processing petitions for Reimbursement Disputes and Utilization Review, ensuring the validity of the submitted petition;
- Compilation, validation and maintenance of monthly statistical reports for the Workers' Compensation Medical Services Unit and Bureau to include recommendations for action required to obtain accurate measurable outcomes;
- Development, analysis, and reporting concerning trends relative to medical reimbursement disputes and utilization review referrals;
- Designing/creating and/or assisting in the creation of spreadsheets, databases and other documents to enhance the reporting and tracing capabilities of the Workers' Compensation Medical Services Unit and other sections within the Bureau;
- Responding to external customer telephone calls and e-mails by providing assistance to questions regarding policies, rules and regulations with referral of complex issues to appropriate medical staff;
- Providing technical assistance to Workers' Compensation Medical Services Unit and Bureau staff related to computers, printers, copiers that do not require assistance from Agency's Information Technology (IT) Department. Developed, maintains, and updates the Workers' Compensation Medical Services Unit and Bureau's Web pages;
- Assisting with development and revisions to administrative rules;
- Assists management to ensure the all processes within the Workers' Compensation Medical Services Unit have written procedures;
- Reviewing, analyzing and generating reports so medical staff can determine patterns and trend practices of health care providers in the Workers' Compensation system
- Producing and submitting data request to the agency's IT Dept. to resolve outstanding technical issues involving the Workers' Compensation Medical Services Unit and the Bureau;
- Providing technical expertise to the ARAMIS medical program in DFS;
- Entering all applications received for HCP and EMA certification into the tracking system and processing HCP Applications. (Nurses process the EMA applications to ensure that criteria for certification are met.);
- Maintaining a paper backup file for the HCP and EMA databases according to the Agency's emergency plan;
- Providing clarification to HCP's related to the HPC certification rule;
- Assisting with the quality assurance program for the HCP and EMA databases; and
- Providing administrative assistance to the Workers' Compensation Medical Services Unit: Assisting with monthly statistical reports, typing and proofreading the reimbursement manuals,

typing letters, filing, typing requisition forms, and performing other general secretarial duties such as processing monthly supply orders and processing travel requests.

Currently, the AHCA Workers' Compensation Medical Services Unit is composed of the following personnel and positions:

- 1 Supervisor
- 5 Registered Nursing Consultants
- 1 Registered Nurse Specialist
- 1 Medical/Health Care Program Analyst
- 1 Operations Analyst 1
- 1 Workers' Compensation Examiner
- 1 Word Processing Systems Operator
- 1 Research Assistant
- 1 Operations Analyst 1 (position is currently vacant)
- 1 Government Operations Consultant 1

When the WC Medical Services Unit was transferred over to AHCA effective August 1999, under a Memorandum of Understanding, there were 29 positions. The Unit was statutorily transferred to AHCA effective July 2002. At present, fourteen staff members perform a number of nursing, technical, and professional duties while fifteen positions have been eliminated from the original WC Medical Services Unit. Of the 29 positions transferred, ten were vacant at the time of the transfer and the other five positions became vacant subsequent to the transfer. Those vacant positions were eliminated when the duties were given to other staff.

The following is an examination of the statutory mandates and current impediments to compliance and efficiency:

The Division has mandated that all required medical data be electronically filed with the Division effective March 2005 in accordance with Rule 69L-7.602, F.A.C. After that time, paper submission of required medical data will not be accepted. Electronic submission of data will have the following benefits:

- Enable the Division to monitor carrier compliance of all required medical data.
- Permit the Division to review the required data fields for accuracy, rejecting invalid data, thus ensuring valid data.
- The data analysis necessary to determine appropriate reimbursement levels to health care providers, hospitals and ambulatory surgical centers will be much more efficiently performed.
- Assist the AHCA Workers' Compensation Medical Services Unit in carrying out statutory mandates more efficiently.

If the analysis of medical data and other functions performed by the WC Medical Services Unit were integrated into the Division's organizational structure and mission, it would enable those tasks to be performed as an integral part of the overall workers' compensation regulatory framework. This integration of functions and services would encourage a single consistent vision.

One of the primary obstacles to the WC Medical Unit staff performing their duties in an efficient, thorough manner is the lack of complete access to the data. Impeded access to data impairs their abilities in the following areas:

1. Section 440.13(3)(a), Florida Statutes – Health Care Provider Certification: There are HCP's that are receiving reimbursement and are not certified. Improved access to the medical database will help identify these HCP's more efficiently, thus allowing the carriers to reduce the number of errant payments to non-certified providers and permitting the AHCA Workers' Compensation medical staff to bring those providers into compliance.

2. Section 440.13(8)(a), Florida Statutes – Determination of pattern/practices of over-utilization: The inability to access the medical database impacts AHCA Workers' Compensation medical staffs' ability to determine patterns/practices of over-utilization and identify physicians that are recommending and providing medical treatment in excess of the practice parameters and protocols mandated by statute. Access to the medical database would permit the AHCA Workers' Compensation medical staff to identify providers that provide medical treatment in excess of the practice parameters and protocols mandated by statute and to determine providers' patterns/practices of over-utilization.

3. Section 440.13(9), Florida Statutes – Expert Medical Advisors (EMA): Presently, AHCA WC Medical staff is unable to validate that an expert medical advisor meets all of the criteria to qualify as an expert medical advisor from the current claims data collected and must rely on other resources to complete the certification. Access to the medical database would provide the opportunity for the AHCA Workers' Compensation medical staff to more efficiently validate all of the EMA criteria prior to certification.

4. Section 440.13(11)(a), Florida Statutes – Health Care Provider Audits: The AHCA Workers' Compensation medical staff does not have an efficient methodology to conduct provider investigations regarding HCP compliance with Chapter 440, Florida Statutes, and promulgated rules and whether providers are engaging in over-utilization and improper billing practices or they are adhering to established practice parameters and protocols. Workers' Compensation Medical Services Unit staff investigates providers upon receipt of a carrier's complaint about provider compliance. There is not, at present, a reasonable way to access provider or carrier patterns by query of the medical database to determine the depth of the perceived problem. Access to the medical database would not only permit the AHCA Workers' Compensation medical staff to fully investigate a carrier's complaint related to a specific provider, but would also facilitate proactive screening and investigation through provider audits to identify providers not in compliance with statutes and administrative rules.

5. Section 440.13(12), Florida Statutes – Guides of Maximum Reimbursement: While the WC Medical Services Unit does respond to specific requests for assistance from the Three-Member Panel, the CFO, and DWC, it is not the most efficient use of the Medical Services Unit. Given the medical expertise of the Medical Services staff, the efficient use of this expertise to assist the Division in developing medical policies is an essential part in the development of the reimbursement manuals. In addition to the actual development of the Maximum Reimbursable Allowances (MRA), reimbursement policies within each of the manuals in conjunction with the MRA's promotes optimal utilization of services and ultimately results in responsible medical cost containment.

   If given the ability to perform routine queries, as well as ad hoc investigations prompted by patterns of specific complaints, questions, inquiries and other such feedback and interaction with providers and consumers, the medical staff would be better able to identify issues that could

ultimately impact reimbursement polices which in turn would promote high quality, cost-effective medical care.

Without access to medical data available, the medical staff is unable to be proactive and only able to be both reactive and inefficient in accurately assessing the relative significance of a complaint or issue.

Having sufficient access to data would improve the Three-Member Panel process, which typically has to hear public testimony and complaints or concern without any prior insight on the issue. The Three-Member Panel must then order an investigation or analysis of the issue to be followed up on at a subsequent Panel meeting, causing delays and frustration.

Access to the medical data by the medical staff would permit them to more effectively assist in the development of the reimbursement manuals. Even though the Division has mandated electronic filing of the medical data and the Division has implemented data element edits to ensure valid medical data, these edits cannot address technical medical issues in the received medical data. Therefore, prior to the submission of the medical data reports to the Three Member Panel, the expertise of the AHCA Workers' Compensation medical staff is required to review the data and identify other aberrant data that requires further investigation. The medical expertise in the AHCA Workers' Compensation Medical Services Unit provides this additional review. Rather than doing this prior to Three-Member panel meetings, routine reviews could be conducted to ensure the availability of quality data.

5. Section 440.13(13)(f)(g), Florida Statutes – Removal of physicians from the health care provider certification list: The AHCA Workers' Compensation medical staff is unable to directly access the medical database during the investigation of a provider that could result in the provider's removal from the certification list. Access to the medical data during investigative process would provide more information and accurate analysis.

6. Section 440.13(14)(b), Florida Statutes – Fees charged for medical care: Lack of accessibility to the medical database inhibits the Workers' Compensation medical staff from identifying health care providers who charge in excess of the applicable fee schedules for medical services. While this responsibility primarily rests with the carrier, the lack of access to the most current data by the Medical Services staff prevents them from functioning in the most efficient manner possible.

7. Section 440.13(16), Florida Statutes – Standards of Care: Inaccessibility to the medical data inhibits the AHCA Workers' Compensation medical staff's ability to determine if treatment rendered is scientifically logical and that the procedures match the diagnosis. While an appropriately credentialed physician makes the final determination, the lack of access to the data makes it difficult to identify outliers. Standards of care could be integrated into provider audits.

8. Section 440.13(8)(b), Florida Statutes – Assessment of penalties on HCP: The Workers' Compensation Medical Service Unit has the authority to assess penalties on health care providers for violation of Chapter 440 and promulgated rules or engaging in a pattern or practices of over-utilization. Due to lack of access to the medical data, the AHCA Workers' Compensation medical staff is unable to conduct a complete investigation regarding complaints patterns or practices of over-utilization. In the 2 years since the WC Medical Services Unit has been officially transferred to AHCA, there have not been any cases of a provider being fined for non-compliance.

Dispute Resolution

Examination of the dispute resolution and litigation volume and pattern analysis may be one of the best indicators of how well the workers' compensation system is working. This is especially true of medical issues and the effectiveness and efficiency of the health care delivery system. The familiar workers' compensation axiom -- "medical drives the claim" -- is certainly validated by the 2002 study by the Three-Member Panel. The study showed that medical-related disputes were associated with over 95% of all petitions, second only to attorneys' fees which ostensibly were associated with 98-99% of petitions, inherent as a structural mechanism for assigning fees. Therefore, any bottleneck or other dysfunction of the dispute resolution system could have significant negative effects regarding timely determinations of medical necessity, access to care, return to work, and/or other assignment of benefits.

The current statistics demonstrate no change in volume for total petition filings. Petition filings on cases involving pre-reform (October 2003) dates of accident have increased slightly. Petition filings on post-reform dates of accident have decreased. There is some indication that the 2003 statutory amendments are effecting some downward turn in petition filings.

An alternative methodology for dispute resolution utilizing a medical peer-review system for medical-related disputes should be considered. This would serve to expedite and enhance the accuracy, relevancy and predictability of those issues, while freeing up the current JCC-based system for administrative and legal disputes and overall case disposition. In addition, it would have the additional impact of enhancing well-reasoned treatment decisions and improving case outcomes by minimizing delays in medical determinations.

Conclusions and Recommendations

In summary, this report's focus is on facilitating mechanisms to ensure that the benefits of those reform efforts are preserved and implemented, principally by rectifying any unintended consequences of the reform process and removing any significant implementation obstacles identified to date. To that end, the following recommendations are offered:

1. The focus should be on supporting and clarifying implementation of existing reform efforts. It is too early to specifically assess the effectiveness or full impact of the reform efforts.

2. The AHCA WC Medical Services Unit should be transferred to the Department of Financial Services, Division of Workers' Compensation to consolidate and integrate all functions with regard to medical issues in workers' compensation regulation, education, compliance, and oversight. This would also permit the Division to design and implement a comprehensive and cohesive outreach and education program regarding medically-related statutory and regulatory provisions, especially medical and functional related issues and offer it to health care providers and all other relevant parties, such as carriers, nurse case managers, and employers.

3. Consideration should be given to grant the Division statutory authority to enforce health care provider (HCP) compliance regarding medical services, reporting, and billing provisions, including the DWC-25 requirements. All stakeholders must be treated equally and held accountable for their behavior and outcomes.

4. The Legislature should enact an alternative dispute resolution model to manage medical disputes.