Three-Member Panel Biennial Report

2015 Edition

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INTRODUCTION

The Legislature enacted Senate Bill 108 in 2002 and included a charge to the Three-Member Panel, Section 440.13(12)(e), F.S., to assess the adequacy of medical reimbursement, access to care, and other aspects of the health care delivery in Florida's workers' compensation system. Beginning in 2003 and biennially thereafter, the Three-Member Panel has presented, to the Speaker of the House of Representatives and to the President of the Senate, a report on ways to improve the Florida workers' compensation health care delivery system. Over the years, the reports have offered recommendations in a number of areas where regulatory efficiencies might be realized and where impediments to cost containment and access to care could be abated or eliminated.

The 2015 Three-Member Panel Biennial Report provides a status on the recommendations contained in the two previous reports. Each of those reports can be accessed via the Division of Workers' Compensation website at www.myfloridacfo.com/Division/wc. The 2011 and 2013 reports address a variety of public policy issues, from changing the reimbursement methodology for hospital services and repackaged drugs to electronic medical billing and eliminating certification requirements for health care providers to treat workers' compensation patients. Several legislative and regulatory solutions have been implemented that have taken into account the Panel's recommendations and position statements. The 2015 Biennial Report also describes the legislative rule ratification challenge the Three-Member Panel is facing in trying to fulfill its statutory duties.

LEGISLATIVE RATIFICATION OF REIMBURSEMENT MANUALS

S. 440.13(12)(a), F.S., states that the Three-Member Panel shall annually adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. S. 440.13(12), F.S., also contains explicit provisions that dictate the amount of reimbursement payable to various health care providers.

The Division of Workers' Compensation (Division) presents recommendations to the Three-Member Panel on reimbursement and policy changes to the Health Care Provider Reimbursement Manual, Hospital Reimbursement Manual, and the Ambulatory Surgical Center Reimbursement Manual. The Three-Member Panel receives public comment on the proposed changes and either adopts the recommendations, amends the recommendations, or does not accept them. The Three-Member Panel's recommendations are implemented within each respective reimbursement manual. The Division undertakes administrative rulemaking in order to formally adopt each manual. The opportunity for public comment is extensive beginning with Three-Member Panel meetings through the Division's rulemaking process.

In 2010, the Legislature enacted changes to Chapter 120, the Administrative Procedure Act. These changes require each state agency to submit for legislative ratification any rule that meets one or more of the following criteria:

1. The rule is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;
2. The rule is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or
3. The rule is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

Florida has a $3.2 billion workers' compensation marketplace, impacting hundreds of thousands of employers, thousands of health care providers, and hundreds of insurance companies licensed to write workers' compensation insurance. Consequently, annually updating the reimbursement amounts to be consistent with the law is likely to meet the third criteria because of the scope and reach the reimbursement manuals have on the parties within the system.

In an effort to balance the competing aspects of the Administrative Procedure Act and s. 440.13(12), F.S., the Division of Workers' Compensation has taken the position that the rules incorporating the reimbursement manuals are subject to legislative ratification despite the statutory authority given to the Three-Member Panel to determine maximum reimbursement allowances and despite the explicit provisions that dictate the amount of reimbursement payable to various health care providers contained in s. 440.13(12), F.S.

During the last several legislative sessions, the Legislature has not ratified updates to the Health Care Provider Reimbursement Manual as requested by the Division of Workers' Compensation and the

Three-Member Panel. Health care providers are currently being reimbursed based upon out-dated Medicare rates, rather than the most recently adopted rates.

RECOMMENDATION

The Three-Member Panel recommends that the reimbursement manuals become exempt from the legislative ratification requirements of Chapter 120, F.S. S. 440.13(12), F.S., already provides statutory authority to the Three-Member Panel to establish maximum reimbursement allowances and contains specific provisions on reimbursement amounts that are payable to health care providers.

1. The Panel recommends that the Legislature consider amending section 440.13(12)(c), F.S., to create a new reimbursement benchmark that reduces the financial disparity between repackaged and non-repackaged drugs; provides a reasonable and standardized level of reimbursement to those parties that dispense prescription drugs; and minimizes future reimbursement disputes related to prescription drugs. Absent a legislative solution, the Panel recommends that the Division of Workers' Compensation explore regulatory options to achieve these goals.

   Status: Senate Bill 662 became law on July 1, 2013. The bill was a compromise between employer/insurer interests and the advocates of physician dispensing of prescription drugs. The law provides that reimbursement for relabeled or repackaged drugs is 112.5% of the average wholesale price set by the original manufacturer of the underlying drug dispensed by the practitioner, based upon the manufacturer's average wholesale price published in the Medi-Span Master Drug Database as of the date of dispensing. NCCI estimated that the cost savings of the changes in Senate Bill 662 would result in a cost savings of -0.7% or -$20 million.

   Medical data reported to the Division of Workers' Compensation reflect the following initial results.

   - **The total payments for physician-dispensed repackaged drugs decreased 39% from $50,051,562 to $30,599,651.**
   - **The total payments for pharmacy-dispensed repackaged drugs decreased 52% from $1,421,189 to $684,832.**
   - **The total payments for all repackaged drugs decreased 39% or $20,188,268, from $51,472,751 to $31,284,483.**
   - **The total for physician-dispensed non-repackaged drugs increased 100% from $11,669,066 to $23,393,247, while pharmacy-dispensed non-repackaged drugs total payments decreased from $119,943,433 to $113,755,642.**
   - **The total payments for all non-repackaged drugs increased 4% or $5,536,390, from $131,612,499 to $137,148,889.**
   - **The total payments for all drugs dispensed by physicians or pharmacies decreased 8% or $14,651,878, from $183,085,250 to $168,433,372.**
   - **The total number of repackaged prescriptions dispensed by both physicians and pharmacies decreased 41% from 10,382 to 6,076 for pharmacies and from 321,232 to 188,069 for physicians.**

   See the attached exhibits at the end of the report for more information.

2. Remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for outpatient hospital services to be based on a percent of "usual and customary charges" and fix the reimbursement amounts to 120% or 140% of Medicare's payments under its Outpatient Prospective Payment System; or, in the alternative;

3. Define the term "usual and customary charge" – so that all stakeholders are aware of its intended meaning and when it is to be used in determining reimbursement for medically necessary treatment, care and attendance provided in an outpatient hospital setting.

4. Remove the statutory mandate in s. 440.13(12)(a), F.S. that requires reimbursement for inpatient hospital services to be based on per diem and fix the reimbursement amounts to 120% or 140% of Medicare's payments under its Inpatient Prospective Payment System.

Status for Recommendations 2, 3, and 4: A new edition of the Florida Hospital Reimbursement Manual will become effective on January 1, 2015 and replaces the 2006 edition. The new edition reflects reimbursement methodologies recommended by the Three-Member Panel. Significant changes have been made to the reimbursement amounts for inpatient and outpatient services.

Hospital inpatient services are reimbursed based on per-diem rates, which includes a Stop-Loss Reimbursement threshold. The changes to the per-diem rates and the Stop-Loss Reimbursement threshold adopted by the Three-Member Panel are as follows:

- **The per-diem rates at trauma centers increases from $3,305 to $3,850.33 for surgical stays, and from $1,986 to $2,313.69 for non surgical stays.**
- **The per-diem rates at acute care hospitals increases from $3,304 to $3,849.16 for surgical stays, and from $1,960 to $2,283.40 for non-surgical stays.**
- **The Stop-Loss Reimbursement threshold increases from $51,400 to $59,891.34.**

After seven years of extensive debate, deliberation, and rule challenges, a consensus was reached for calculating a "usual and customary charge" for hospital outpatient services. This "usual and customary charge" methodology is summarized below.

- **18 months of hospital outpatient charge data is used.**
- **A minimum of 40 bills per procedure are used to calculate a statewide average charge per qualifying procedure.**
- **The statewide average charge per qualifying procedure is then discounted by 25% or 40% depending on whether the procedure was associated with a scheduled surgery. By law, hospital outpatient surgical procedures are reimbursed at 60% of charges, while all other hospital outpatient procedures are reimbursed 75% of charges.**
- **The discounted statewide average charge per qualifying procedure is then modified by a Medicare geographic wage adjustment factor based upon the location of the service to attain the Maximum Reimbursement Allowance (MRA) per qualifying procedure.**
- **Procedures not subject to an MRA will be reimbursed 60% or 75% of the hospital's charges.**
- **The number of procedures subject to an MRA at 60% of usual and customary charges is 163.**
- **The number of procedures subject to an MRA at 75% of usual and customary charges is 339.**

The cumulative effect of the changes to the inpatient and outpatient reimbursement amounts results in an overall cost savings of -0.8% or $26 million. This reduction was included in the January 1, 2015 NCCI Workers' Compensation Rate Filing, which was approved by the Office of Insurance Regulation.

5. Eliminate the health care provider certification process performed by the Division. The criterion for certification would then become the standards used by Florida's Department of Health declaring all practitioners who are currently in good standing regarding their licensure to practice in their respective discipline and specialty as eligible to be authorized by carriers and to receive reimbursement for services rendered.

   Status: House Bill 553 became law on July 1, 2013. One of the provisions in the bill eliminated the health care provider certification process performed by the Division of Workers' Compensation.

6. Amend section 440.13(7), F.S., to allow providers 45 days from receipt of a notice of disallowance or adjustment of payment to file a petition; allow carriers 30 days from receipt of a provider's petition to respond to the petition; and allow the Department 120 days from receipt of all documentation to issue a determination.

   Status: House Bill 553 increased the reimbursement dispute process timelines for health care providers, carriers, and the Division of Workers' Compensation, which reflect the Three-Member Panel's recommendation.

1. Electronic Medical Billing (E-billing)
It is the Panel's recommendation that the Division continue its current practice of permitting health care providers to electronically submit medical bills to insurers, provided the insurer agrees to accept the submission of electronic medical bills. In addition, the Panel is recommending that the Division develop an action plan with the goal of determining whether to mandate electronic billing no later than 2015.

Status: The Division of Workers' Compensation held a public meeting on April 1, 2014 to solicit input from stakeholders about the advantages and disadvantages of mandating electronic medical billing between the health care provider and the insurer. Comments from the meeting suggest that E-billing continues to grow in Florida. Although there was general agreement that E-billing may lead to quicker payments to providers and reduce administrative costs compared to issuing and processing paper bills, pursuing a mandate and implementing a "one-size fits all" approach may prove to be the least effective method to expand the use of E-billing. Unless providers and insurers specifically request the Division to mandate a standardized E-billing requirement, the Division of Workers' Compensation should continue to promote mutual-agreeable E-billing practices between the provider and the insurer.

2. Practice Parameters and Protocols of Treatment
The Panel recommends that the Legislature give serious consideration to repealing section 440.13(15), Florida Statutes, and replacing it with an alternative that effectively translates the mandates of section 440.13(16), Florida Statutes, (Standards of Care) into meaningful treatment guidelines.

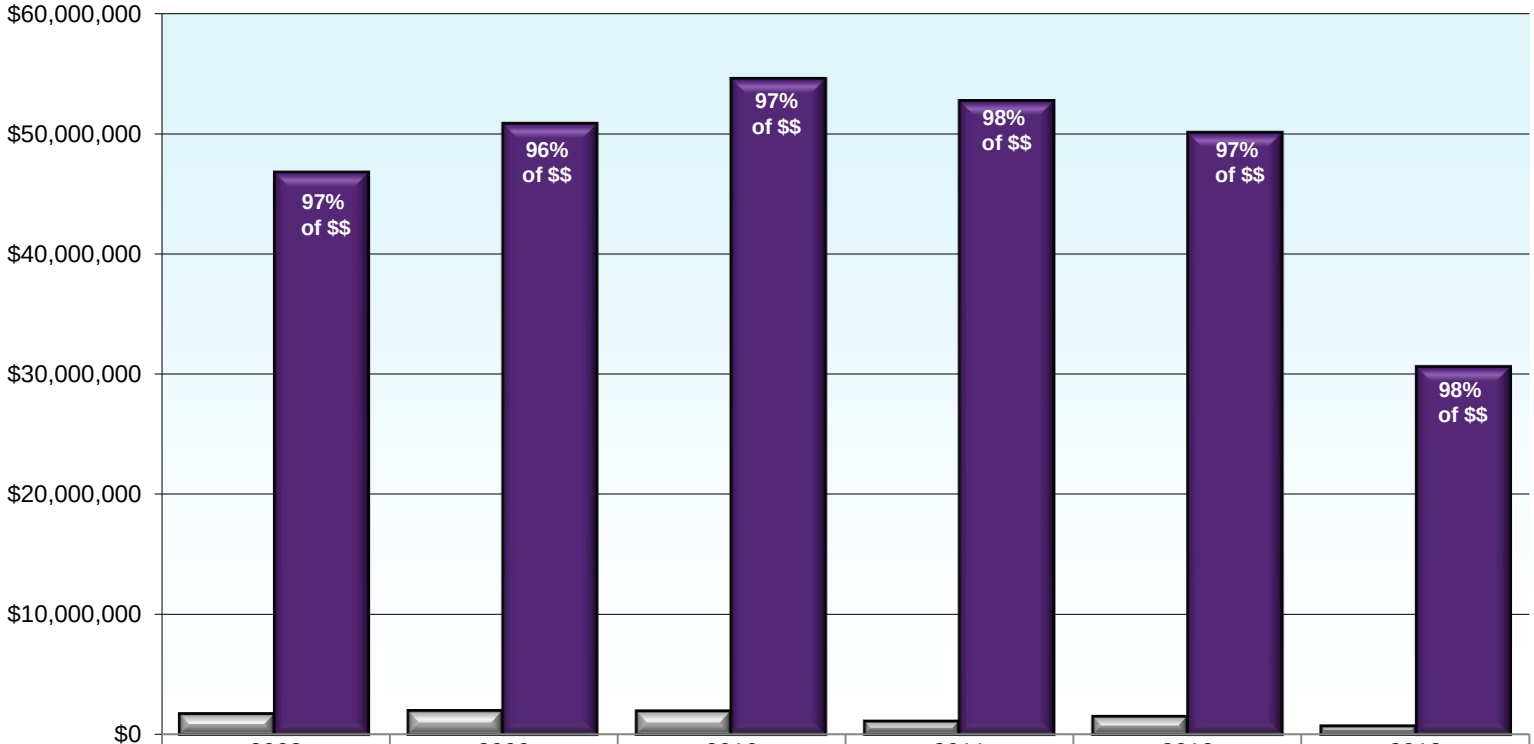
As a foundation for the above recommendation, the Panel recommends that the Legislature conduct or commission an analysis of the various types and sources of available practice guidelines to determine which is most appropriate for Florida and determine how it should be developed and implemented.

Status: The Legislature has taken no action on this recommendation.

3. The Florida Uniform Permanent Impairment Rating Schedule
It is the Panel's recommendation that the Legislature consider authorizing an interim study to determine whether to retain, update, amend, or replace the Florida Uniform Impairment Rating Schedule.

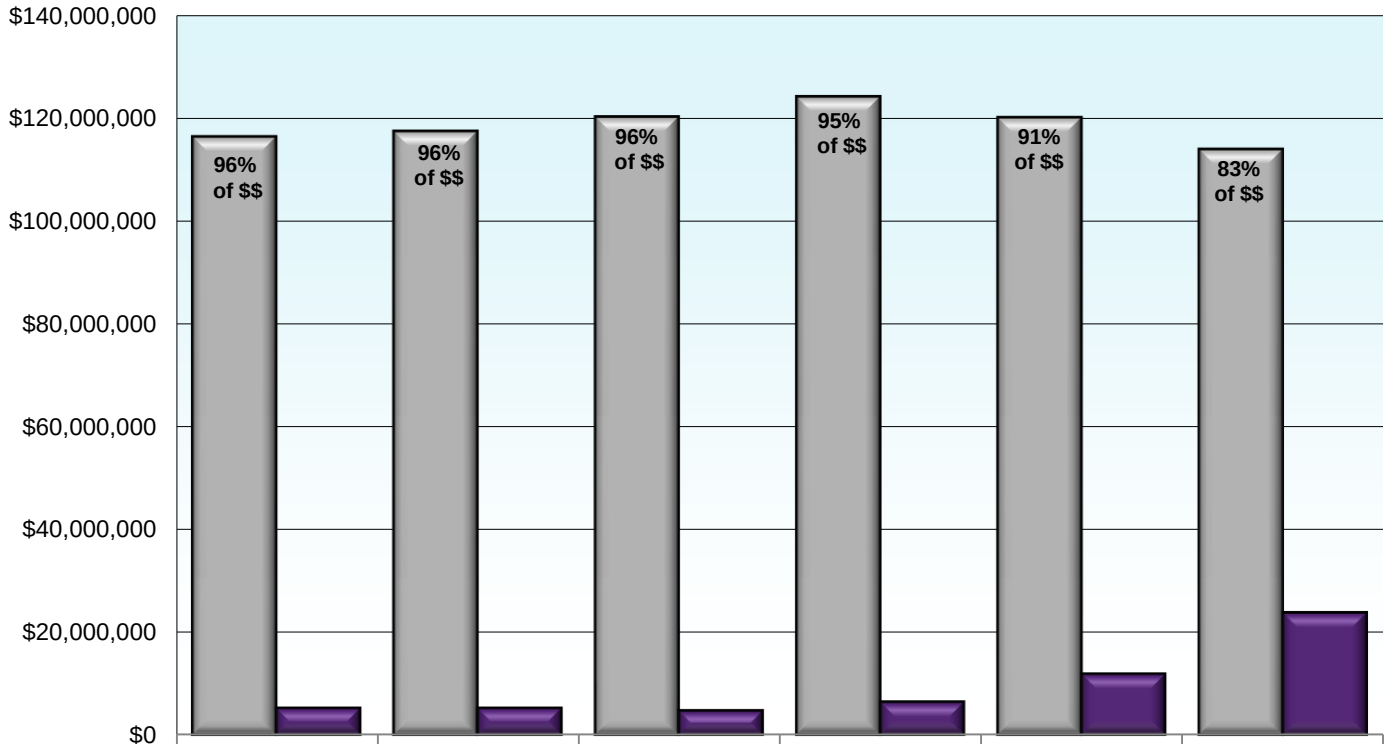
Status: The Legislature has taken no action on this recommendation.

Pharmacy vs. Physician Repackaged Drug Payments



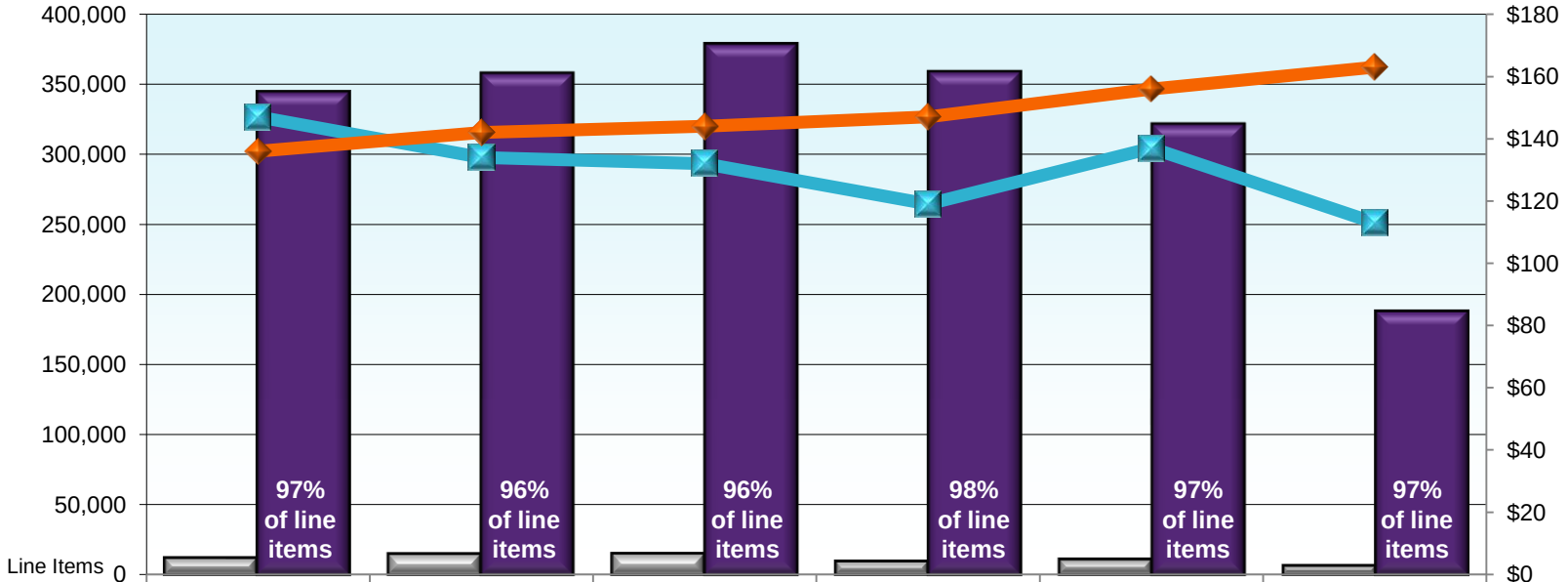
	2008	2009	2010	2011	2012	2013
Pharmacy Repackaged Total Payments	$1,655,418	$1,883,399	$1,866,837	$1,071,158	$1,421,189	$684,832
Physician Repackaged Total Payments	$46,748,580	$50,789,715	$54,527,237	$52,684,976	$50,051,562	$30,599,651

Pharmacy vs. Physician Nonrepackaged Drug Payments



	2008	2009	2010	2011	2012	2013
Pharmacy Nonrepackaged Total Payments	$116,190,096	$117,253,351	$120,057,700	$123,996,090	$119,943,433	$113,755,642
Physician Nonrepackaged Total Payments	$5,161,920	$5,129,464	$4,633,770	$6,341,326	$11,669,066	$23,393,247

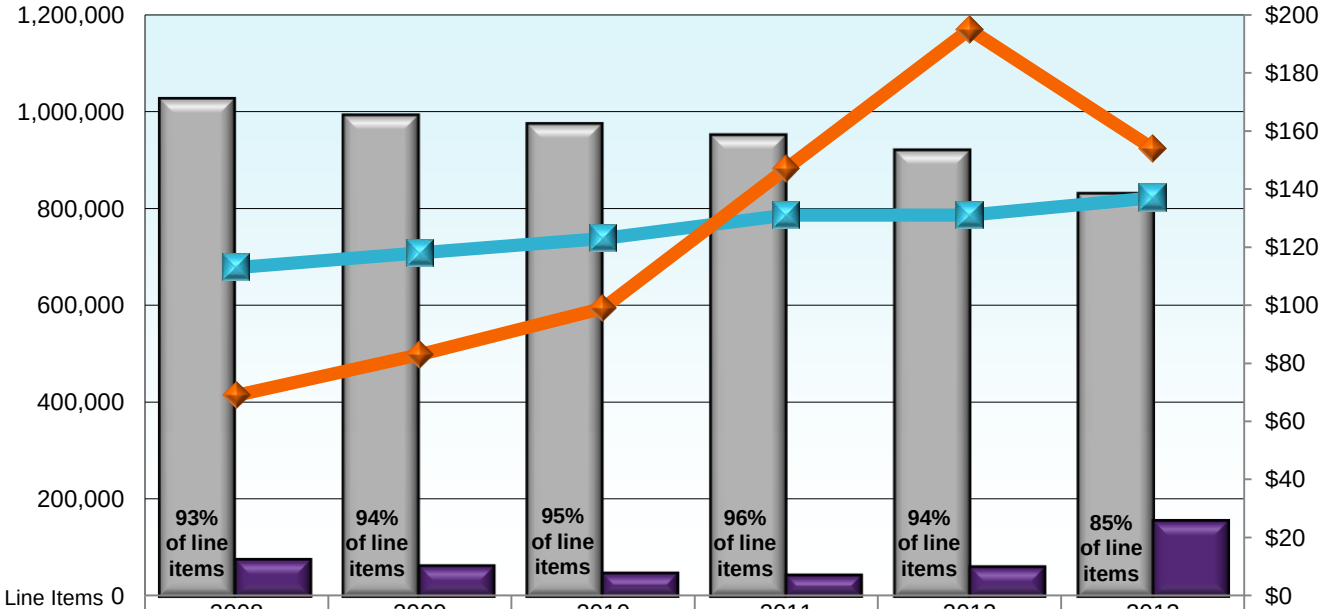
Pharmacy vs. Physician Repackaged Drugs



	2008	2009	2010	2011	2012	2013
Pharmacy Repackaged Line Items	11,226	14,058	14,132	8,977	10,382	6,076
Physician Repackaged Line Items	344,307	357,557	378,356	358,506	321,232	188,069
Pharmacy Repackaged Avg $ Per Line Item	$147	$134	$132	$119	$137	$113
Physician Repackaged Avg $ Per Line Item	$136	$142	$144	$147	$156	$163

Graph compares drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians).
Reference to line items also means per prescription.

Pharmacy vs. Physician Nonrepackaged Drugs



	2008	2009	2010	2011	2012	2013
Pharmacy Nonrepackaged Line Items	1,024,752	991,002	973,247	950,132	918,589	829,543
Physician Nonrepackaged Line Items	74,582	61,838	46,995	43,094	59,806	151,891
Pharmacy Nonrepackaged Avg $ Paid Per Line Item	$113.00	$118.00	$123.00	$131.00	$131.00	$137.00
Physician Nonrepackaged Avg $ Paid Per Line Item	$69.00	$83.00	$99.00	$147.00	$195.00	$154.00

Graph compares drugs billed on DWC-10 forms (dispensed by pharmacies) to drugs billed on DWC-9 forms (dispensed by physicians).
Reference to line items also means per prescription.