Three-Member Panel

Biennial Report

2009 Edition

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INTRODUCTION AND BACKGROUND DISCUSSION

The Florida Legislature enacted Senate Bill 108 in 2002, which included an explicit mandate in s. 440.13(12)(e), Florida Statutes (F.S.), that the Three-Member Panel assess the adequacy of medical reimbursement, access to care, and other aspects of the health care delivery system in the Florida Workers' Compensation program. The Three-Member Panel was directed to issue an initial report in January 2003 with succeeding reports due biennially thereafter to the President of the Senate and the Speaker of the House of Representatives on methods for improving Florida's workers' compensation health care delivery system. The initial 2003 report led to many of the medically related reforms enacted during 2003 in Senate Bill 50A (SB 50A).

However, the most comprehensive analysis and set of recommendations to improve the delivery of health care in Florida's workers' compensation system are presented in the 2007 Three-Member Panel Biennial Report. Therefore, in the interest of minimizing redundancy and to promote brevity, where appropriate, the Panel has referred your attention to the 2007 Biennial Report for detailed background on its recommendations and conclusions as members of the legislative body may desire.

The Office of Medical Services' (OMS) recent formal transfer to the Division of Workers' Compensation, effective July 1, 2008[1], represents the completion of a Panel recommendation provided in the 2005 and 2007 Biennial Report. The Office of Medical Services is organized into four programmatic areas. Those areas are 1) certification of health care providers, 2) certification of expert medical advisors, 3) resolution of medical reimbursement disputes, and 4) determination of patterns and practices of overutilization and investigation of other health care provider violations under Chapter 440, F.S. The OMS also collaborates with the Division's Bureau of Data Quality and Collection to revise administrative rules for medical billing and reimbursement manuals for health care providers, hospitals, and ambulatory surgical centers.

The Panel reaffirms the recommendation previously made in the 2007 Biennial Report that the Legislature continue to build on the productive relationship that already exists with the Division, taking full advantage of the wealth of data and expertise available at the Division when considering any legislative activity involving workers' compensation. Moreover, the Panel encourages the Legislature to follow through on the remainder of the recommendations contained in the 2007 Biennial Report.

[1] Prior to the legislative enactment via House Bill 5045, the Office of Medical Services had been co-located at the Division of Workers' Compensation headquarters under an interagency agreement between the Agency for Health Care Administration (AHCA) and the Department of Financial Services (DFS). The agreement had been in effect since November, 2005.

Health Care Provider Certification

The Florida workers' compensation health care delivery system continues to require mandatory health care provider certification. Therefore, the Division is amending the current Health Care Provider Certification Rule.[2] The amended rule will have a definition for "recognized health care provider" which will clarify the providers subject to certification under the rule. However, certification provides no verifiable additional benefit to the workers' compensation system nor does it promote increased access of injured employees to health care providers knowledgeable of or dedicated to optimal outcomes for injured employees.[3]

To that end, the Panel reiterates the recommendations provided in the 2007 Biennial Report (page 48) that the Legislature eliminate the current workers' compensation health care provider certification process performed by the Division and allow those practitioners who are currently in good standing with the Department of Health regarding licensure to provide remedial treatment, care, and attendance to injured workers. Alternatively, it is strongly recommended that the Legislature enable the Division to create an optional certification designation for providers following attendance and completion of a workers' compensation education course which emphasizes the unique requirements of the workers' compensation health care delivery system and aligns with the Division's oversight of providers' patterns and practices for appropriate use of health care resources. The program would be provided exclusively under the direction, control and express association of the Division.

In order to implement the above recommendations, the Legislature would need to amend the language of s. 440.13(3), F.S., to remove the certification requirement as a prerequisite to health care provider reimbursement.

Practice Guidelines and Evidence Based Medicine

Directly related to the unique considerations of the workers' compensation health care delivery system and the Division's oversight of providers, the Panel reiterates its recommendation to integrate evidenced-based medicine (EBM) into the Florida workers' compensation system by ***eliminating*** the current language in s. 440.13(15), F.S., and ***revising*** s. 440.13(15), F.S., to adopt the following statutory framework.

In addition to and consistent with clinical definitions, criteria and standards already outlined in the 2007 Biennial Report, all medical and related decisions shall be made utilizing evidenced-based medicine (EBM) as defined in the following ***hierarchy***:

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[2] The Health Care Provider Certification Rule, Chapter 69L-29, F.A.C., was formerly Chapter 59A-29, F.A.C., under the Agency for Health Care Administration.

[3] For a discussion of the administrative burden to both the Division and the health care provider, see pages 44 through 46 of the 2007 Biennial Report.

a. **Specific Research Support:** Highest level of deference - Specific, relevant, scientific studies published in widely-respected juried journals, i.e. random controlled trials (RCT), systematic reviews of controlled trials.

b. **Professional Consensus:** Second level of deference - Integrating science and practice, i.e. evidenced-based practice guidelines or other relevant position papers from widely recognized organizations.

c. **Principle-Based (*inherent logic*):** Third level of deference - established and well-defined clinical reasoning applied to relevant anatomical, physiological, pathological, and clinical principles. Case-specific data (objective, relevant exam findings), outcomes and measures should be utilized for accountability.

d. Deference by ***all*** parties should be made regarding medical and related decisions and determinations to those best supported by and consistent with the clinical definitions, criteria and standards outlined elsewhere in Chapter 440, F.S., and via evidenced-based criteria as outlined above.

e. Regarding intention and competency, there should be a deference on behalf of the treating practitioners, and therefore recommendations and requests for evaluation, diagnostic testing, and/or treatment should be routinely approved unless there are specific, relevant, merit-based reasons to question or deny authorization (i.e. requested service is clearly not necessary, appropriate, or additional information or clarification is required). This same deference should be applied in dispute resolution or determination of practice patterns in that, given essentially equal levels of documentation and support for either side of a dispute between the treating clinician and a consulting clinician, the treating clinician would be given deference. This does not eliminate the requirement and responsibility of the treating physician to utilize evidenced-medicine as defined above, nor does it eliminate the employer/carriers' responsibility or the obligation to question, or if appropriate, deny services that are not consistent with the evidenced-based provisions outlined above.

The above recommendation requires the ***insertion*** of language in the s. 440.02, F.S. (i.e. definition section):

a. ***Evidenced-based medicine*** is defined as the conscious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients, the practice of which requires integrating individual clinical expertise with the best available clinical evidence from systematic research.

b. ***Practice Guidelines*** are defined as systematically developed statements to assist practitioner and patient/consumer decisions about appropriate health

care for specific clinical circumstances. They are a set of statements, directions, or principles presenting current or future clinical rules or policy concerning the proper indications for performing a procedure or treatment or the proper management for specific clinical problems.

Reimbursement

Information in the 2007 Biennial Report revealed that submission of practitioner reimbursement disputes had decreased proportionally since the increase in maximum reimbursement allowances (MRAs) resulting from the enactment of SB 50A benchmarking reimbursement to Medicare. The report encouraged additional alignment with Medicare cost containment through code editing designed to minimize inappropriate payments from potential reporting abuses. As a result, the Division has recognized the National Correct Coding Initiative (NCCI) edits in the most recent health care provider reimbursement manual[4]. Thus, at this time, the Panel reiterates the 2007 recommendation that the current methodology for physician and other practitioner reimbursement should ***not*** be altered as it is certainly having a positive effect on the delivery of medical services to injured employees.

However, the challenges related to facility reimbursement have not abated. Much has happened to alter facility reimbursement since this Panel submitted the 2007 Biennial Report. To summarize, the First District Court of Appeals, in the case of One Beacon Insurance v. Agency for Health Care Administration[5] ruled against AHCA in a medical reimbursement dispute relating to the proper construction of "usual and customary charges", which were extensively discussed in the 2007 Biennial Report.[6] The Court found that it was the intent of the Legislature to eliminate calculation of a "usual and customary charge" based on the fees of any one provider, in favor of a calculation of such charge based on average fees of all providers in a given geographical area.

In order to comply with the Court's ruling, the Department of Financial Services, Division of Workers' Compensation embarked upon the task of recommending a payment method to the Three-Member Panel that would reimburse hospitals for outpatient medical services based on "usual and customary charges" as required by statute[7] and by the One Beacon decision. The Department enlisted the services of Research and Planning Consultants (RPC), L.P. to assist in identifying and recommending a hospital payment method that would meet the legislative and judicial standards. RPC issued its report and recommended that the Department and the Three-Member Panel adopt Medicare's outpatient prospective payment method in conjunction with appropriate payment adjustment factors resulting in hospitals being paid 60 and 75

[4] The Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition became effective on Monday, February 9, 2009.
[5] The ruling is available at Florida's First District Court of Appeals web site: http://opinions.1dca.org/written/opinions2007/3-28-07/05-5459.pdf
[6] See pages 32 through 39 of the 2007 Biennial Report for a more detailed discussion of "usual and customary charges".
[7] F.S. 440.13(12)(a).

percent of usual and customary charges, thus meeting the statutory requirements in the One Beacon decision.

On March 18, 2008, at a public meeting of the Three-Member Panel, the Division recommended that the Panel adopt Medicare's hospital outpatient prospective payment method as proposed by RPC. The Panel, after an interim period in which interested parties were encouraged to provide questions, concerns and alternative proposals to the Division, adopted the RPC recommendation at its November 20, 2008 public meeting.

The One Beacon decision underscores the need for legislative enactment to uncouple facility reimbursement from any specific reimbursement methodology. In so doing, the Panel would acquire the flexibility to not only study but to adopt the most appropriate reimbursement methodology to meet its primary and statutory responsibility to ensure injured employees access to quality care at an affordable cost to the employer. Therefore, the Panel reaffirms the recommendations previously offered in the 2007 Biennial Report to review and revise statutory language concerning the specific reimbursement methodology for inpatient and outpatient hospital services in order that the Three-Member Panel meets its legislative obligations under s. 440.13(12)(d) and (e), F.S.

To accomplish those obligations, all of the following are necessary:

a. 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.

b. 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".

c. Require the Three-Member Panel to consider reimbursement methodologies representative of resource consumption and provider costs associated with the provision of services when determining uniform schedules (e.g., diagnosis related groups, outpatient prospective payment system).

d. Either define the word "reasonable" or delete it altogether as a standard against which the reimbursement schedules are measured (s. 440.13(12)(d), F.S.).

e. Require that reimbursement for the same or similar services provided at different locations or by different providers shall not exceed the lowest reimbursement established for any provider of the service unless a higher reimbursement is agreed to in writing pursuant to s. 440.13(14)(b), F.S.

Electronic Submission of Medical Bill Data from Health Care Provider to Insurer

Florida's Division of Workers' Compensation permits health care providers to electronically submit medical bills to an insurer, provided the insurer agrees. As of May 2003, HIPAA (Health Insurance Portability & Accountability Act) mandated that all health care providers billing for medical services rendered to patients covered by Medicare, Medicaid, private health insurance, etc., must utilize national electronic standards, specifically version 4010, to transmit medical data required for the adjudication of a medical bill. The HIPAA format utilizes the standards developed by the Accredited Standards Committee which was chartered in 1979 by the American National Standards Institute. This directive applies to all health care providers with limited exceptions.

While state workers' compensation programs are exempt from compliance with HIPAA requirements, the same health care providers who are required to comply with HIPAA regulations, and who are treating patients covered under Medicare, Medicaid, and private health insurance also treat injured employees covered under the Florida Workers' Compensation system. Therefore, it is reasonable to allow health care providers to utilize the *national* electronic standards' software existing in their offices, thereby, eliminating any additional administrative burden on the providers.

Currently, two large states, California and Texas, have passed legislation requiring Workers' Compensation insurers to accept workers' compensation medical bills submitted by health care providers in an electronic format. In these states, stakeholders were not opposed to submitting workers' compensation medical bills electronically, but were adamant that the electronic billing format for the workers' compensation programs utilize the HIPAA compliant software programs already in use.

The willingness on the part of California and Texas health care providers to electronically submit workers' compensation medical bills appears to be a position shared by a number of Florida health care providers. During the first quarter of calendar year 2008, the Division of Workers' Compensation surveyed a random sample of workers' compensation certified physicians asking, among other things, about their then current level of electronically submitted medical bills.[8] The results suggest that many health care providers have already started migrating toward the electronic submission of medical bills.

HIPAA regulations have subsequently changed to adopt a revision to the national electronic standards known as the 5010 version, setting a compliance target date for all providers to convert to the 5010 version by April 1, 2010[9]. Additionally it is anticipated that the International Classification of Diseases, 10th Revision-Clinical Modification

[8] Of the 234 providers responding to the question, 53 percent indicated filing at least some portion of their medical claims via electronic submission. And, 43 percent of respondents indicated filing a majority of their medical claims electronically.

[9] For a detailed discussion of HIPAA and activities to enhance the national electronic standards please see pages 11 through 14 of the 2007 Biennial Report.

(ICD-10-CM) will be adopted for implementation by health care providers and all payers by October 2, 2011.

Stakeholders have a monumental task to modify software programs by the above-referenced dates. While the Florida workers' compensation program should continue to consider mandating the electronic transmission of medical bill data and all other medical data required to adjudicate a medical claim, the Division should:

a. Continue to permit health care providers to electronically submit medical bills to insurers, provided the insurer agrees to accept the submission of electronic medical bills, and;

b. Continue to evaluate and analyze the results from Texas and California regarding the outcomes of their respective mandates, and determine what, if any, benefits such a mandate would have on Florida's workers' compensation system. However, the Division should consider delaying adoption of any mandatory use of electronic billing until 2010.

Education & Training

"The department shall educate all persons providing or receiving benefits pursuant to this chapter as to their rights and responsibilities under this chapter."[10]

On a daily basis, the Division provides education to employees, employers, health care providers and other stakeholders through telephonic and e-mail customer assistance lines, and publications such as the 2008 System Guide, periodic workshops and participation in industry conferences. To restate a significant point of the 2007 Biennial Report, it is imperative that the Division provide comprehensive, authoritative instruction to all parties to avoid conflicting interpretations due to extensive lack of understanding.

A prime example of an outreach initiative which, when fully realized, will produce system wide benefits is more refined training on the proper use of the *Uniform Medical Treatment/Status Reporting Form*, Form DFS-F5-DWC-25 (DWC-25). The DWC-25 was created as the sole and exclusive Division-required form to be completed by the physician. The form allows timely physician communication with any insurer and/or employer to report the medical status of the injured employee. The form includes identification of functional restrictions and limitations to enhance earlier return to work, the establishment of maximum medical improvement and assignment of the permanent impairment rating, documentation of the physician's determination of whether or not the work related accident or injury is the major contributing cause of the employee's need for medical care and provides the injured employee with timely information about his/her condition. In addition, the DWC-25 is a written request for authorization that facilitates timely approval of medically necessary treatment of the injured employee, hence enhancing timely access to medical care.

[10] Subsection 440.207(1).

The purpose for having the DWC-25 as a standardized communication tool is to reduce the volume of paperwork flowing between the provider and insurer offices while enhancing communication between the insurer, provider, employer and patient concerning the injured employee's treatment and status with the goal of providing the best, most timely medical care to the injured employee. While its use is increasing, for this goal to become reality, the DWC-25 must become a central component of the physician and insurer business matrix. The DWC-25 will promote improved communication only if both stakeholders begin to integrate the form and the wealth of patient status information it contains (when properly completed) into their respective patient decision support model. It is the need for this type of refined stakeholder training that underscores the Division's continued need to maintain its proactive and progressive outreach and training initiatives. These initiatives help ensure that all system stakeholders are accurately and fully informed of relevant statutory and regulatory provisions.

Conclusion

This report is an augmentation to the extensive and detailed 2007 Biennial Report. The recommendations herein have been carried forward from its predecessor. The salient point of this report is the need to continue the good work formerly started with respect to implementation, execution and integration of workers' compensation reform provisions.