

Workers' Compensation Legislative & Regulatory Update

from McConnaughay, Duffy, Coonrod, Pope & Weaver, P.A.

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Volume 9, Issue 3
March 28, 2008

The Florida legislature is moving forward with a number of workers' compensation bills that address several administrative and technical changes to Chapter 440, Florida Statute. The sole legislative recommendation submitted by the Division of Workers' Compensation is expected to be approved by lawmakers. The bill would complete the statutory transfer of the workers' compensation medical services from the Agency for Health Care Administration to the DWC. Currently, the division is overseeing those functions per an interagency agreement. Another bill addresses expert medical witness fees in cases where a witness is compelled to testify in a workers' comp case. One insurance issue being considered is a provision that would grant the state's four current self-insurance funds the authority to distribute policyholder dividends without prior regulatory approval. The trial bar has also filed a bill that would make changes in attorneys' fees and make certain changes in claimant's benefits.

The trial bar provision is part of three bills addressing the insurance contracts

of professional employment organizations with their client companies. The bills' PEO provisions are basically identical and are designed to address several areas that have been the source of criticism over the past several years. Namely, the bill sets out the procedures for clarifying which entity is responsible for providing workers' comp coverage to specific employees and under what terms. The PEOs would also be responsible for computing the experience modification factor for the client company. As the session progresses, there is the expectation that any number of proposed changes to Chapter 440 could be offered as amendments to filed bills.

Meanwhile, the Division of Workers' Compensation is preparing to conduct its' own analysis of the impact of the 2003 reforms on the workers' comp system. The study is still in the early stages and division officials have yet to identify all the areas that will be included in the review. The study will be primarily based on the information collected by the division in the period between 2004 and 2007. The study will be separate from other reviews being conducted by the National Council on Compensation Insurance and the Workers' Compensation Research Institute.

Finally, the three-member panel has considered changes to the medical reimbursement schedules.

AHCA Transfer to DWC

The Jobs and Entrepreneurship Council has approved a proposed committee bill (PCB JEC 08-04), which will statutorily transfer the workers' compensation medical services provided by the Agency for Health Care Administration (AHCA) to the Division of Workers' Compensation (DWC). As a proposed committee bill, the legislation has a clear path to full House approval and it is expected to receive Senate approval. The bill, however, could run into trouble if it is amended to make unfavorable changes to Chapter 440, Florida Statute. If approved, the bill will become effective on July 1.

In 2005, an interagency agreement moved AHCA's Workers' Compensation Medical Services Unit to the DWC, which assumed the unit's day-to-day operation. Under Chapter 440.13, Florida Statutes, the unit oversees the certification of health care providers, expert medical advisors, and maintains the database of certified providers that can be accessed by employer/carriers. The

unit also handles medical reimbursement and utilization disputes between health care providers and insurers.

The bill doesn't affect the internal operations of the DWC with respect to the medical services unit, which has been fully integrated into the division. The main impact of the bill is a change in the rulemaking process. Under the current process, many of the DWC and AHCA rules either overlap to some extent or affect similar areas. For example, AHCA has the statutory authority to levy fines in cases where providers are engaged in improper business practices, while the DWC has the ability to fine insurers for not complying with provider reimbursement regulations. If the bill passes, all rule making authority would fall under the DWC.

Expert Witness Fees

The House Safety and Security Council has approved a proposed committee bill (HB 7023), sponsored by Rep. Dennis Ross (R-Lakeland), which includes a provision regarding expert witness fees. Specifically, the bill states that a witness that testifies per a subpoena in a workers' comp case shall receive the same fees as a witness in a civil case. The bill defines an expert witness as the following: "An expert witness is a person duly and regularly engaged in the practice of a profession who holds a professional degree from a university or college, and who has had professional training and experience, or a person possessed of special knowledge or skill about the subject upon which he or she is called to testify." The definition replaces the current statutory language that defines an expert witness under Rule 1.390(a) of the Florida Rules of Civil Procedure.

Ross' bill is a comprehensive bill that addresses a long list of civil court rules. Currently, it is on the House calendar and ready for a full House vote. Sen.

Alex Villalobes (R-Miami) has an identical bill waiting in the Senate (SB 2300), and the bill is expected to be enacted by the full legislature. It would take effect on July 1.

Self-Insurance Funds

The Jobs and Entrepreneurship Council has approved HB 1161, sponsored by Rep. Don Brown (R-DeFuniak Springs), addressing the distribution of policyholder dividends by group self-insurance funds. The bill is identical to SB 2462, sponsored by Sen. Don Gaetz (R-Ft. Walton Beach).

Under current law, the trustees of a group self-insurance funds can decide to pay a dividend to policyholders if the fund's surplus exceeds the fund's financial obligations. First, however, the fund must obtain permission from the Office of Insurance Regulation. Under the bill, the four existing self-insurance funds would not have to secure regulatory approval to distribute the dividends, but must inform OIR within 10 days of doing so. Funds created after June 1, however, would still have to gain OIR approval for a period of seven years so that regulators could ensure the fund's solvency.

PEOs

There are three pending bills addressing PEOs, all of which have similar language. In the House, Rep. Dave Muzin (R-Pensacola) is sponsoring HB 239, which is currently waiting to be heard by the Jobs and Entrepreneurship Council. Senator Jeff Atwater (R-North Miami Beach) is sponsoring SB 454, which is assigned to the Senate Banking and Insurance Committee. Also in the Senate Banking and Insurance Committee is a bill sponsored by Sen. Alex Villalobes (R-Miami), bill (SB 2548), which in addition to the PEO language contains provisions supported by the trial bar.

At issue in the PEO bills is making sure that the organization and client companies are meeting the terms of the state's compliance laws and that employees are aware of their coverage status. The major issues clarified in the bill are as follows:

- All leasing companies are required to have a workers' comp policy.
- PEO/client company agreements must state who is responsible for providing coverage, i.e., the client company or the PEO.
- The PEO must give written notice to workers stating whether the PEO/client company is responsible for providing workers' comp coverage. PEOs are required to inform a leased employee by mail when a PEO/client agreement leasing agreement ends.
- PEOs must notify leased employees of the termination of their workers' comp coverage if the PEO terminates or layoffs the employee. Establishes standards for notification to employees.
- The workers' comp exclusive remedy provision is extended to the PEO and client company regardless of which entity provides workers' comp coverage to the worker.
- Records necessary for calculating an experience modification factor must be provided.

While lawmakers are moving forward with HB 239 and SB 2548, they have yet to take action on SB 2548, which contains provisions favorable to the trial bar. Though SB 2548 itself is not moving forward, the provisions are likely to be offered as amendments to any of the workers' comp bills including those addressing PEOs, the transfer of AHCA to the DWC, and other pieces of legislation that touch on Chapter 440. These provisions are as follows:

- Claimants could have more than one change of physician, but must pick a physician in the managed care net-

work. Employer/carriers would be required to pay for one independent medical exam and removes the current law, which confines the IME to one per accident. In effect, this would reopen the door to having multiple IME's per medical specialty.

- The bill extends the payment and eligibility for supplemental and impairment benefits. The changes primarily reinstate the pre-2003 law.
- If the claimant attorney fee based on the statutory schedule is less than the cost paid to a defense attorney by an employer/carrier, the schedule would not apply. The claimant attorney fee would have to equal the defense fee or a reasonable fee as dictated by a judge of compensation claims.

DWC Study

The 2003 law gave the DWC wide-ranging authority to collect a variety of information, especially claims and medical data. The law changes have led to the implementation of a list of rules governing the electronic submission of records through the division's electronic data interchange system. The DWC's stated goal was to create a database that gives the most up-to-date picture of the system's administration. The study is likely to become a blueprint that will be continually updated to provide information to regulators and the legislature.

The DWC has contacted a number of individuals involved in the workers' compensation system to solicit their response to the study as part of the process. DWC officials have not set out any timetable for conducting the review and stress that while it may touch on public policy issues, there are no plans at this time to formulate any legislative recommendations. And while the review may be cited in some quarters as a reason not to entertain any legislative

law changes to the 2003 reforms this year, it doesn't preclude lawmakers from addressing any issues.

Three-Member Panel Action

The Three-Member Panel on Workers' Compensation has approved the newest edition of the Florida Workers' Compensation Health Care Reimbursement Manual, which could mean a small increase in some provider reimbursements after the federal government adjusted the Medicare rates. The National Council on Compensation Insurance says the changes could cost an estimated \$4.8 million, which represents a 0.1 percent rate impact. The approval comes as the panel signed-off on a proposed Division of Workers' Compensation study to formulate a method to create a uniform system for calculating hospital outpatient fees, which includes defining what is a "usual and customary" charge. Currently, outpatient services are reimbursed at 60 percent of an individual hospital's charges. In addition to calling for a uniform definition of usual and customary, the study is needed for the state to conform to a recent court ruling that states that outpatient services' rates must be set on the average costs of hospitals in a given geographic area. The DWC and its Medical Services Unit have issued a report examining the state's involvement in settling medical reimbursement disputes between providers, hospitals, ambulatory surgical centers and employer/carriers.

Health Care Reimbursement

The Three-Member Panel on Workers' Compensation has approved the 2008 Florida Workers' Compensation Health Care Reimbursement Manual,

which will result in a small increase in some providers' payments. The 2003 law tied provider reimbursements to the Medicare fee schedule as calculated by the federal Centers for Medicare and Medicaid Services. Specifically, the 2003 law set the maximum reimbursement amounts for surgical procedures at 140 percent of Medicare and non-surgical procedures at 110 percent. The specific services are roughly calculated using a Resource Based Relative Value System (RBRVS) times a conversion factor. For 2008, the CMMS increased the Medicare conversion factor from \$37.8975 to \$38.0870.

The National Council on Compensation Insurance calculated that the change in the manual would result in a 0.1 percent increase in overall workers' compensation costs, which equals \$4.8 million. NCCI indicated the increase would be reflected in the 2009 annual rate filing. According to the council, the system's total medical costs account for 69.1 percent of the overall workers' comp dollar.

The 2003 law specified that the physician reimbursement changes applied to all physicians defined in Chapters 448 and 459, Florida Statutes. The three-member panel later included in the reimbursement manual other providers such as chiropractors, optometrists, podiatrists, and registered nurse practitioners. Under the Medicare-based payment system, health care fees are adapted to specific geographic boundaries that reflect several factors including a doctor's patient load, practice expenses such as equipment and supplies, and medical malpractice insurance premiums. Florida is divided into three geographic areas with the highest adjusted fees applying to providers in Dade and Monroe counties. The second highest reimbursements are in a geographic area encompassing Broward, Collier, Indian River, Lee, Martin, Palm Beach,

and St. Lucie counties. Physicians in all other counties are reimbursed at the lowest rate.

Outpatient Hospital Costs

The Three-Member Panel on Workers' Compensation has given the DWC the okay to move forward with conducting a study on how to standardize the reimbursements for outpatient hospital services. At a recent meeting of the panel, the Research & Planning Consultants—which were retained by the division—issued its report examining the current methodology used to pay hospitals and several scenarios to calculate an industry-wide payment method. Currently law provides that outpatient physical, occupational, and speech therapy must be reimbursed per the physician fee schedule, along with any radiological and clinical laboratory service not related to a surgical procedure. The outpatient surgeries are reimbursed at 60 percent of usual and customary charges.

At issue is how to define “usual and customary” and create a valid methodology that would lead to a fee schedule that would be applied to all outpatient surgeries. The consultants pointed out that usual and customary was traditionally defined as the billed charges per the individual hospital's charge. Critics point out that this payment scheme allows hospitals to determine their reimbursements unilaterally since they control their charges, which, in theory, can be changed on a daily basis. The First District Court of Appeal recently ruled in *One Beacon v. AHCA (32 FLW D1578)*, that a legislative change in 1994 prohibited the calculation of a usual and customary charge on a per hospital basis in favor of the average fees of all hospitals in a given area. The ruling, however, leaves open the ques-

tion of how to define or determine the fees and geographic zones.

The consultants recommended that Florida follow the example of six other states and tie outpatient hospital rates to the Medicare system. Specifically, the fees would first come from the Medicare Outpatient Prospective Payment System, which establishes payment rates for most all outpatient services. In addition to the OPPTS method, Medicare has four other fee schedules including one to cover physical, occupational, and other outpatient rehabilitation services. Then there is a clinical lab fee schedule, a prosthetics and orthotics and supplies fee schedule, and ambulance fee schedule.

As for *Beacon v. AHCA*, the consultant recommended that rather than trying to match up the charges of hospitals and determine geographic areas, the state implement a Medicare-based system. Like the current state provider fee schedule, the hospital fees would be calculated using Medicare's schedule with a payment adjustment factor. For example, Tennessee sets outpatient fees at 150 percent of Medicare. Medicare already divides the state into three geographic zones, which would resolve the questions raised in *Beacon*. The three-member panel instructed the DWC to move forward with a study of the possibility of implementing a Medicare system and/or defining usual and customary charges. The changes must also be revenue neutral. The DWC plans to submit a report to the panel at a later date.

Provider Dispute Report

AHCA released its annual report detailing the outcome of Petitions for Resolution of Medical Reimbursement Disputes for 2007. Under state law, any health care provider who objects to a carrier's decision to disallow or other-

wise modify a payment for a medical bill can petition the AHCA's Office of Medical Services to resolve the dispute. In 2007, the office received 2,065 petitions as compared to the 953 petitions filed in 2006. Officials say the increase is likely due to an increasing awareness of the process. In 2004, the office only received 306 petitions.

The petitions are split into three categories: hospitals; ambulatory surgical centers; and health care providers. Hospitals generally account for the majority of petitions filed, with 713 petitions filed last year. The number of hospital and ambulatory center petitions remained fairly stable between 2006 and 2007. However, the number of provider reimbursements increased significantly. The majority of the increase is due to petitions from pharmacists, durable medical equipment suppliers, and emergency medical transportation providers. The OMS is looking to modify its Automated Reemployment and Medical Information System to provide new classifications for services that currently fall under the provider category.

Looking at outcomes, the OMS made 542 final determinations. Of those cases, officials found that the provider had been underpaid in 459 cases. OMS dismissed 1,139 cases. Of that number, 414 dismissals came after a petitioner failed to remedy a deficiency in the petition as indicated by the office. Further, 348 dismissals were due to untimely filed petitions and 377 dismissals were due to the fact that the dispute fell outside of OMS' jurisdiction.