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January 12, 2021

What's New In Our Industry
Florida

I. Executive Branch of Government - Administrative

A) HOSPITAL FEES

1. Introduction

According to the latest biennial report from the Florida Three Member Panel, hospital costs have become a significant issue in controlling overall costs in the Florida workers' compensation system. On average, country-wide, 58% of total benefits paid in workers' compensation benefits were for medical. In Florida, 69% of the total benefits paid relate to medical services provided. A very significant component of medical services paid relates to hospital costs (both inpatient and outpatient) more specifically stated as follows:

A. Hospital Outpatient Services - According to the Workers' Compensation Research Institute (WCRI), Florida's outpatient costs per claim were substantially in excess of the median state charges countrywide. Outpatient payments per claim in Florida have increased at a greater rate than most states studied and in fact Florida had the highest outpatient payments of the states studied. Hospital outpatient payment in Florida were 441% of Medicare rates whereas countrywide, rates were 256% of Medicare according to the National Council on Compensation Insurance (NCCI).
Regionally, payments were 223% of Medicare.

B. Inpatient Services – According to NCCI, Florida's hospital inpatient payments as a percentage of Medicare were 346% whereas the countrywide averages were 191%. The average cost per inpatient service in Florida amounted to $40,929 whereas countrywide it was $29,876. The average inpatient amount paid per day for hospital inpatient services was $6,915 in Florida but $5,397 countrywide. Regionally, the per diem average for all inpatient care was $4,448 per day.

C. Ambulatory Surgical Centers (ASC) – Costs for ASC services in Florida were 312% of Medicare whereas countrywide it was 285%. The average amount paid per visit for ASC services in Florida was $5,505 whereas countrywide $4,420.

1. Overview

Florida's response to growing concerns about hospital fees has basically been considered through various system interpretations, more specifically discussed in Administrative Law Judges (ALJ) recommended orders in accordance with Chapter 120, Florida Statutes, and through the development of recommended alternate fee schedules as related to hospital services. Each of these recommended administrative actions and fee schedules will be described below.

2. Administrative Law Recommended Order Decisions

The decision in *Pacific Employers Insurance Company v. Department of Financial Services, Division of Workers' Compensation*, Case No.: 20-21 dated September 18, 2020, dealt with outpatient hospital services. According to statutory mandates as found in Section 440.13, Florida Statutes, hospital outpatient bills are payable based upon 75% of the usual and customary charges. By rule, the Division created an exception to the applicable reimbursement standards for certain treatments. With exceptions, the hospital would be paid 60% of "usual and customary charges." By statute, "usual and customary charges" were those charges that were paid in the geographical area where the costs were incurred. The only evidence presented by the hospital at the time of the hearing in regards to the payment of hospital outpatient services related to the usual and customary charges for Florida as a whole. The ALJ found that usual and customary charges statewide for determining reimbursements of charges was not relevant in determining reimbursements for hospital outpatient services. Rather, usually outpatient hospital services must be determined in the provider's geographical area, i.e., in a specific geographical area where the services were performed, not the state as a whole. Any attempt by the Division to interpret usual and customary charges on a statewide basis would be contrary to the statutory definition of usual and customary charges and therefore an invalid exercise of legislative authority.

A second recommended order was decided by an ALJ was the opinion in *Zenith Insurance Company v. Department of Financial Services, Division of Workers' Compensation Medical Services*, Case No.: 18-3844 dated May 8, 2019. This case discussed Division rules concerning inpatient hospitalization costs. In accordance with Section 440.13(12)(a), Florida Statutes, inpatient charges are paid on a per diem basis. To the contrary, the maximum fee scheduled adopted by the Department provided for inpatient reimbursements based upon a stop-loss reimbursement basis that provided for per diem reimbursements up to a stop-loss amount ($59,891.34) and thereafter payment at 75% of the billed charges by the hospital. The ALJ's recommended order stated that since the Department's reimbursement schedule with a stop-loss provision was different from the per diem statutory reimbursement provisions, this constituted an invalid exercise of legislative authority. Per diem amounts should be the sums that were payable. Accordingly, the per diem payment schedule prevailed in determining the amounts payable for inpatient medical services. The use of the stop-loss method of reimbursement for inpatient services constituted an invalid exercise of delegated legislative authority.

3. Division of Workers' Compensation Responses to ALJ Decisions

The Division basically ignored the ALJ decisions as above summarized. Evidence of this came with the filing of the new Reimbursement Manuals. On December 17, 2020 the Workers' Compensation Three Member Panel held a public meeting to consider adoption of proposed changes to the Hospital Reimbursement Manual, the Ambulatory Surgical Center (ASC) Manual and the Provider Reimbursement Manual, as recommended to them by the Florida Division of Workers' Compensation. Following approximately a two hour meeting with public comment, the Three Member Panel voted unanimously to approve the proposed changes. Formal rulemaking procedures will be followed as hereinafter provided to formally adopt the Three Member Panel's conclusions. The primary changes are:

A. Hospital Inpatient Reimbursement Rates (Excluding Surgical Implants)

The current hospital reimbursement rate, in effect since 01/01/2015, has included a per diem rate of approximately $2,300 for non-surgical stays and approximately $3,850 for surgical stays. However, the current Manual includes a 'stop-loss", which provides that if the hospital charges more than $59,891.34, the per diem is ignored and the carrier will pay 75% of whatever the hospital charges. After a legal challenge to the 'stop loss" and "percent of billed charges" method, an ALJ issued a Recommended Order finding that this method was illegal and in violation of the statute. As a result, the Division recommended the new methodology as follows:

Per diem of $3,000 for non-surgical stays and $4,500 for surgical stays, plus, a new, 5 tiered system of reimbursements with a system of 4 stop-losses, again based on billed charges, before a final Maximum Reimbursement Allowance, if the billed charges reach the 5th tier. Each tier level is now multiplied by the applicable per diem amount time that tier level. For example, tier 1 is 1 times $4,500, tier 2 is 2 times $4,500, etc. until the final tier is paid at 5 times $4,500 for a final per diem of $22,500.00.

Employer and carrier representatives argued to the Panel that this new system perpetuates the same system of incentivizing hospitals to charge to the highest tier to maximize payment, even though the highest tier was theoretically reserved for severe spinal cord, brain injury and severe burn cases. The hospital industry argued that charges did not have to be reasonable to be paid, and they supported the change. Panel members suggested that NCCI projected a premium decrease, and that their role was limited to reviewing and approving the proposals suggested by the Division, and any 'outlier' charges or payments were not significant enough in their view to support a different payment methodology.

B. Hospital Outpatient Reimbursement Rates (Excluding Surgeries and Implants)

In effect since 01/01/2015, the manual defines "usual and customary" as a statewide average or 'mean' charge for procedures and services, where there are at least 40 items billed under that CPT code to Florida Workers compensation carriers in the previous 18 months. Then, a base rate of .6 times the "usual and customary or 'average charge' is applied before using the payment

methodology. For scheduled outpatient surgeries, payment is at 60% of the base rate. For all other services besides scheduled surgeries, payment is at 75% of the base rate.

If however there are not enough 'qualifying charges',i.e., 40 or more, the payment is still either 60% of the hospital's billed charge for scheduled outpatient surgery and 75% of billed charges for everything else, with some exceptions such as for implants, etc.

C. Hospital Outpatient Surgery Rates

The only proposed change is to adopt by rule a new definition of "usual and customary." If there are less than 40 qualifying procedures to meet the current definition, the 'base rate' is ignored, and the payment is either 60% of that single hospital's charge or 75% of that hospital's charge, plus a Medicare wage rate multiplier for the geographic location.

D. Surgical Implant Rates

1. For Hospital Inpatient Surgery:
Reduce from Invoice cost plus 60% methodology to acquisition cost plus 30%.

2. For Hospital Outpatient Surgery:
Change from:

60% of usual and customary for scheduled outpatient and 75% of usual and customary for unscheduled (emergency) outpatient, to:

Define "usual and customary" as two times invoice acquisition cost, then reimburse at 60% or 75% for scheduled and unscheduled surgeries, respectively.

E. For Ambulatory Surgery Center (ASC) Rates (Excludes Surgical Implants)

Keeps most Maximum Reimbursement Allowances (MRAs) current in effect with MRA calculated at 60% of statewide average 'usual and customary' for procedures with 50 or more bills.

For procedures with less than 50 bills paid by workers' compensation in Florida over a 4 year period, the usual and customary amount is the 'average' and payment is 60% of the average. For single procedure averages, payment is 60% of billed charges.

1. For ASC Surgical Implants:

Current payment is acquisition invoice cost plus 50%.
Proposed change is acquisition invoice cost plus 30%.

F. Healthcare Provider Reimbursement Manual (All other Providers)

Current rate is 140% of Medicare for surgical procedures, and 110% of Medicare for non-surgical services. Changes are needed to update the current 2020 Medicare Conversion Factor and RBRVS geographic specific rates.

4. Next Steps for Final Approval of Reimbursement Manuals As Above Described

Considering the changes to the Healthcare Provider Reimbursement Manual summarized above, this will probably produce a cost increase of one million dollars. Accordingly, the update will need to be approved by the Legislature.

The Division did not expect that the Hospital or the ASC manuals will need Legislative approval, as NCCI suggested that the new methodologies would produce a cost savings. However, some carriers have been skeptical that costs will increase, and any rate savings is based primarily on the reduced number of accident claims submitted to the system, along with the reduced medical severity of the average claim, even while the actual costs of at least some of these claims seems to have increased according to some data and anecdotal surveys.

B) PHARMACY BILLS

Definition of "Pharmacy" for Dispensing Medications Under Chapter 440, Florida Statutes

Informational Bulletin DWC-01-2020 issued March 31, 2020 by the Division of Workers Compensation determined that carriers could not refuse to authorize reimbursement for practitioner dispensed medication solely on the basis that a dispensing practitioner is not a pharmacist. Reversing its own policy, the bulletin states that sick or injured employees have a right to choose to have their prescriptions dispensed by their chosen pharmacy, see section 440.13(3), F.S., and a licensed dispensing practitioner is considered a pharmacy in the Division's view. The Florida Workers' Compensation Healthcare Provider Reimbursement Manual 2016 Edition explicitly recognizes the dispensing of drugs by licensed dispensing practitioners to injured workers and provides a methodology for determining the appropriate reimbursement amounts. The reimbursement amount for a prescription is the Average Wholesale Price (AWP) plus $4.18 for a dispensing fee. For repackaged or relabeled dispensed medication by a dispensing practitioner, the fee schedule for reimbursement is 112.5% of the AWP plus $8.00 for a dispensing fee. Prescriptions for compensable medication are payable by carriers to authorized treating physicians registered to dispense under Section 465.0276, Florida Statutes, if the injured worker chooses to have a prescription dispensed and filled by the authorized treating physician.

This opinion by the Division, as referenced in the informational bulletin referenced above, is contrary to a decision by the Department in the case of *In the Matter of Todd Alea*, Case No.: 122698-11-WC, adopted by the Department on August 31, 2012. The ALJ recommended order was dated July 17, 2012. In our view, this position is also contrary to the pharmacy statute.

Employers should be diligent in recognizing the correct standard for reimbursing pharmaceutical bills.

As indicated below, the Division has now drafted proposed rules to forbid carriers from not authorizing practitioner dispensed medications, and to sanction them if they don't comply. The proposed rules also suggest that, for reasons not explained, lack of medical necessity and therapeutically inappropriate defenses don't apply to practitioner dispensed medication. We believe those proposals are invalid, and should be challenged by carriers.

C) MEDICAL BILL DISPUTE RESOLUTION PROCEDURES

1. Introduction

The Florida Division of Workers' Compensation has been actively engaged in revising mandatory rules relating to carrier authorization of medical care, adjustment of medical bills, and medical reimbursement disputes. The proposed changes to these rules will likely limit the rights of E/C/SAs in the system, while also increasing their administrative responsibilities. Because these proposed changes simultaneously include new rules for aggressive administrative sanctions, including fines and attorney's fees against E/C/SAs, the industry as a whole should feel incentivized to pay attention and appropriately engage with the Division. Unquestionably, these new proposed rules will play a significant role in how claims handlers should oversee the payments of medical bills in the workers' compensation system.

2. Volume of Administrative Proceedings Related to Resolution of Medical Reimbursement Disputes

During FY 2019-2020, 3.6 million medical bills were filed with the Division. Of these bills, the Division received 4,607 Petitions for Resolution of medical bill disputes. The Division reported that 82% of all determinations, medical care providers had been underpaid (facts disputed by industry). However, this statistic fails to count that 2,730 of the 4,607 Provider Petitions (59%) were voluntarily dismissed or withdrawn favorably to the carrier prior to final determination. Additionally, the amount billed did not always equal the amount due. This information was obtained from the Division's report to the Three Member Panel issued in December 2020. Administrative resolution of reimbursement disputes is a huge area of concern of the Division as evidenced by the number of dispute petitions filed, the increased substantive amendments to procedures as described below, and the increased emphasis on penalizing for non-compliance with reimbursement rules which includes the payment of attorney fees.

3. <u>Major Proposed Rule Changes</u>
<u>Related to The Process of Resolving Medical Disputes</u>

- E/C/SAs already must timely respond to all requests for medical authorization under the statute. The Division may apply currently standard penalties, plus sanctions for "pattern or practice" violations, along with attorney's fees and costs.
- An authorized physician is <u>conclusively presumed</u> to also be authorized to dispense all medications he/she chooses in office.
- The E/C/SA may not challenge medical necessity or the therapeutically appropriate dosages of practitioner-dispensed medication. There appear to be no limits on practitioner dispensing.
- The E/C/SA waives 'medical necessity' of any treatment by an authorized provider if: the carrier did not timely respond to a request for authorization, or the carrier did not specifically limit authorization.
- The Carrier or Bill Review entity may only use Division-approved EOB codes to describe the reason for bill adjustment. The E/C/SA may not raise any legal, affirmative defenses supporting bill adjustment that are not covered by an EOB code.
- Once the EOBR is filed, the carrier may not complete an overutilization review process, or any other investigation, to be used in any later reimbursement dispute proceeding. After-acquired evidence of fraud, billing error, overutilization, etc. will not be allowed.
- For 'charge-based' reimbursements, the E/C/SA may not complete a charge audit or any line-item adjustment to establish a 'clean bill' or appropriate charge from which to calculate payments in certain circumstances.
- The E/C/SA may not raise any defense in a Reimbursement Dispute that was not raised by EOB code at the initial bill review stage. After-acquired evidence or documentation is not permitted. The Division apparently abrogates its statutory duty to audit for overpayment, and will not order repayment where appropriate.
- The E/C/SA's failure to file a timely Carrier Response to Provider Petition for Reimbursement Dispute deems the carrier to have waived <u>all defenses</u>. As a result, the Division may determine that the Carrier must pay whatever the Provider has demanded. It remains to be seen whether the provider must first establish authorization, compensability, medical necessity and actually provision of treatment billed.
- The Division will sanction carriers with attorney's fees and with carrier "pattern or practice" violations if they violate any of the newly proposed rules or raise "disfavored" defenses. Sanctions may be applied to any response that the Division dislikes, including responses designed to alert the Division to fraud, mutual mistake, or price gouging.

D) MAXIMUM COMPENSATION RATE

Effective January 21, 2021, it has been determined that the maximum compensation rate for receiving workers' compensation benefits is $1,011. This determination was made by the Department of Economic Opportunity based on this agency's determination of the statewide average weekly wage as provided for in Section 440.12(2), Florida Statutes.

II. Judicial Branch of Government

A) PETITION (CLAIM) FILINGS – FY 2019-2020

A frequently asked question relates to the amount of litigation occurring before Judges of Compensation Claims and what effect if any the Covid pandemic has had requiring the use of the formal litigation processes of the Florida workers' compensation system. The significance of the current level of litigation can best be seen in the years following the 2003 systemic changes in the law.

In FY 2002-2003 (Florida's fiscal year), 151,021 Petitions for Benefits were filed. Following that time, petition filings decreased dramatically and steadily through FY 2012-2013 following which an upward trending began. That upward trending continued until FY 2019-2020 when to the surprise of many, petition filings numbered 72,086, a 1.4% decrease from the previous FY year. The "new case" volume similarly dropped about 1.6%. (There was a very minor downward change in filed petitions in FY 2017-2018.) The question arises as to why there was a drop in petitions filed in FY 2019-2020. In all probability, such a drop is attributable to the Covid pandemic. In July and August 2020, the filings were below the previous year's months. September 20, 2020 saw the petition filings above the previous September but to no great extent. For October and November 2020, filings were lower than the previous November 2019.

B) DECISIONS BY APPELLATE COURT (1st DCA)

Attached (Click Here) are summaries of the opinions issued by the First DCA on workers' compensation issues. These summaries represent the cases decided by the court since the last update. See "Lessons Learned" Section of this newsletter for analysis of cases for effect on adjusting of claims.

III. Legislative Branch of Government

Based on filings made by NCCI and actions taken by the Office of Insurance Regulation, Florida employers will see on average a 6.6% reduced premium base for new and renewable workers' compensation policies effective January 1, 2021. Notwithstanding the fact that the World Health Organization designated the Covid-19 outbreak as a pandemic on March 11, 2020, the filings made for rate approvals and the ultimate decision by the Insurance Commissioner to grant the 6.6% average decreased, expenses for projected costs to be incurred by industry because of the Covid were not considered. Although NCCI authorized a "white paper" attempting to value the unquestionable costs to the workers' compensation system of Covid claims, the rate reduction filed and granted did not include consideration of Covid expected expenses. According to NCCI, "The presence or absence of a pandemic in a recent historical period is not believed to be a reliable predictor of whether one will return in a given future year, after the current one runs its course." This same consideration is given to catastrophic events such as terrorisms and earthquakes. Bottom line, there is an unknown expense associated with Covid claims that at this time is not being considered in the rate determinations. These expenses will ultimately be considered in developing rate filings.

The fact that there has been a rate reduction approved is important in predicting legislative actions concerning workers' compensation since the need for systemic legislative reform in the minds of legislators seemingly is directly related to whether rates go down or up. If going down, there is no problem needing legislative attention. The system is not broken. On the other hand, if rates are going up, there is a need for change. Since rates are going down, systemic changes as viewed by the Legislature are not expected to occur. However, some bills have been filed and will be summarized in the next newsletter.

IV. Lessons Learned

How and why recent events have occurred in the ever-changing workers' compensation world have oftentimes had a real impact on how claims handlers deal with "real life" scenarios. What was the correct way of handling a workers' compensation matter yesterday may not necessarily be the correct procedure to follow today. This section of our newsletter deals with lessons learned when considering the recent changes in the workers' compensation system regardless of whether these changes occur in the executive (administrative), judicial or legislative branches of government. We welcome any comments recipients of our newsletter have in response to these identified issues and appropriate manner of response in the defense of workers' compensation cases. The following are recommendations for handling the defense of workers' compensation claims based upon recent changes:

A. Authorizing Medical Care

Several recent cases summarized above have created a real dilemma for the handling of cases by the employer/carrier in the authorization of medical care for injured workers. Consider this scenario, oftentimes witnessed in the handling of workers' compensation cases:

> The injured worker suffers a compensable accident resulting in knee injuries. An MRI determined that he had extensive preexisting arthritic changes in his knee; however, there is evidence that the accident did result in a need for medical care which was timely authorized by the adjuster. Authorization of medical care was made in general terms saying that treatment for the accident was to the claimant's knee. Over a year after the accident, maximum medical improvement was reached and an impairment rating was given by the authorized doctor who apportioned out of the total impairment rating which existed pre-accident. Apportioned IB benefits were timely paid.
>
> The authorized doctor then determined that the claimant needed a total knee replacement but stated that the major contributing cause and the need for the knee replacement was the preexisting severe arthritic changes, not the job related torn medial meniscus.

Assuming this factual scenario, it would appear that the claims handler would be well advised to not pay for the medical care related to the total knee replacement and any impairment rating that related to the preexisting knee condition. Several court decisions, however, were rendered some of which are summarized above that because of the "120 day rule" contained in

Section 440.20(4), F.S., the employer/carrier would be estopped in claiming that the knee replacement was not compensable as not being related to the accident. When the accident occurred, the adjuster had basically authorized treatment "to the claimant's knee" without specifically stating that treatment only was authorized for any aggravation of the preexisting knee condition. Since 120 days had passed without specifically denying the medical condition which had caused the need for the knee replacement (i.e., preexisting arthritic changes in the knee), the claims handler generally accepted injuries to the knee as being compensable, the employer/carrier was estopped from saying that the need for the knee replacement surgery was not related to the accident.

Lesson Learned:

In accepting or authorizing medical care or in paying benefits, be specific as to exactly what you are accepting as compensable. Don't just say that you are accepting the knee injury as compensable. Rather, the correct manner of accepting compensability of the knee injury in this instance needs to be very specific in regards to the kind of medical condition for which treatment is being provided. For example, authorizing treatment only for the aggravation of a preexisting knee injury. Otherwise, you might be precluded at a later date from denying treatment for medical care that is unquestionably not related to the compensable accident.

B. Paying Medical Bills Including Pharmaceuticals And Understanding Actions that Need to be Taken When Denying or Reducing Bills

As summarized above, a huge amount of administrative litigation (governed by Chapter 120, F.S., the Administrative Procedures Act) is appearing, certainly more to come. Procedures exist and are being developed or amended, failure of which to follow will have an adverse effect on your ability to properly deny or limit payment of medical bills when there is a justification for doing so. No longer can the claims handler rely on a bill review service or other entity to make these decisions. Never before has there been such an urgent need for complete coordination by both the claims handler and the bill payor within the company or contracted with..

Lesson Learned:

With the adoption of new provisions including the payment of attorney's fees and increased attention in assessing penalties by the Division for failure of the claims industry to properly and timely adhere to newly established processes for the denial or reduction of medical bills. In addition, there is also a need to understand in what venue will have jurisdiction to decide these issues, i.e., by the Division of Workers' Compensation administratively or by a Judge of Compensation Claims. Oftentimes, the payment of medical bills will be filed by the claimant's attorney in proceedings before a Judge of Compensation Claims when in fact the Division of Workers' Compensation should be making that decision. Certain procedural defenses are available for the denial or reduction of bills for medical care. For example, a medical provider did not follow proper procedures in requesting the payment of bills and therefore additional defenses are permitted.