**Resolution of Workers’ Compensation**

**Medical Bills and How to Limit Prescription Costs in Florida**

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1. **Scope of Problem**
2. **Report By Division of Workers’ Compensation to Three-Member Panel Regarding the Resolution of Medical Reimbursement Disputes and Actions pursuant to Paragraph 440.13(12)(e), Florida Statutes – FY2019-2020 Dated December 2020**
3. FY 2019-20
4. 4607 Petitions Received
5. 2,274 Practitioners
6. Hospital Outpatient
7. Since FY 15-16
8. Total Petitions Received – 28,000
9. Approximately 500 petitions per year (estimated) have not been dismissed or decided by Division.
10. **Bill Processing Procedures**
11. **The Bill**
12. Must be on Division-required form, Rule 69L-7.710; Appropriate manual for Healthcare Providers, Ambulatory Surgical Centers and/or Hospitals, Rules 69L-7.020, 7.100 and 7.501 respectively.
13. Medical Documentation Supporting Payment which includes at a minimum:
14. Medical treatment notes signed by provider showing the provision of authorized treatment;
15. Division approved form depicting name and licensure of provider as well as name of designated billing agent.
16. **Response by Employer/Carrier to Bill Received, Rule 69L-7.740**
17. Within 45 days:
18. Pay
19. If not payable in whole or in part, issue EOBR utilizing codes listed in Rule 7.740(14)
20. If part of bill not payable and others are payable, issue “minimum partial payment.”
21. **Response by Provider to EOBR, Rule 69L-31, issued by Employer/Carrier**
22. Negotiate with Employer/Carrier re: settling bill payment
23. Within 45 days:
24. File fully completed Petition for Reimbursement Dispute;
25. Petition must include:
26. Disputed bill or service authorized either actual authorization or emergency are;
27. Medical documentation showing service actually performed;
28. Any contract or managed care arrangement concerning treatment.
29. Respond to “Notice of Deficiency” of Petition filed by Division which gives the provider a certain amount of time to provide documentation.
30. Response by Employer/Carrier to Petition filed by Provider:
31. Within 30 days from receipt of a Petition for Reimbursement Dispute filed by provider, file a Response
32. Response must:
33. Be on Division-required form completed in full;
34. Provide all information that is relevant to any adjustment or payment defense which may include peer review and a letter from the employer/carriers medical director;
35. Any relevant reimbursement contract and network agreement. The Employer/Carrier must show/demonstrate the contract applies to the provider and that the contract provisions support the carrier’s adjustment of payment.
36. Failure of Employer/Carrier to file a Response results in a waiver of any arguments the E/C would otherwise be entitled to raise.
37. Dispute Determination §440.13(7), F.S.
38. Payments ordered by Division must be based on a “maximum reimbursement allowance (MRA) or an agreed upon price.
39. Must be “commercially reasonable.” The Division takes the position that where there is no MRA established in a reimbursement manual, certain categories of payment must be based on a percentage of the provider’s “billed charges.” We do not agree with this position in certain instances and therefore subject to challenge.
40. If the E/C fails to respond to a provider petition, the Division will assume that the E/C waives all objections to the petition.
41. Administrative Appeal to DOAH or Alternatively to a Department Hearing Officer
42. Either party may appeal pursuant to the Administrative Procedures Act – Chapter 120, F.S., §§120.569 and 120.57, Florida Statutes.
43. Appeal must be taken within 21 days of receipt of the determination. The appeal must meet certain factual, legal, and uniform pleading requirements. The case is then assigned to an ALJ for determination if there is a dispute of fact or law or for internal review if there is no such dispute.
44. **Frequently Litigated Issues**

1. **Authorization of Doctors or Other Medical Care Providers**
2. Claims handlers are required by law to have written procedures for receiving, reviewing, documenting and responding to requests for authorization. §440.13(e), Florida Statutes.
3. The Division intends to aggressively audit and fine carriers failing to routinely meet the response deadlines for responses to authorization requests as required by §440.13(3), F.S., i.e., response deadlines within 3 or 10 days.
4. Neither statute nor rules state what should be in written procedures. Recommendations:
5. Send Authorization response letters to every provider. The Division pays close attention to the details of authorization letters, including any limitations on treatment, terms of payment, and requests for documentation for utilization review and payment.
6. List the scope of the authorized evaluation and any treatment as specifically as possible. Sanchez v. YRC, Inc./Sedgwick, 304 So.3d 358(Fla. 1st DCA 2020); Sullivan v. NuCo2, LLC/Broadspire, 308 So.3d 659(Fla. 1st DCA 2020)
7. List expectations for medical reporting. Section 440.13(15)(c), Fla. Stat., requires written reports every thirty days, or sooner if applicable.
8. List any payment agreement, if applicable. Try to set a standard or benchmark for payments where no MRA has been established. Include language that all payments must be commercially reasonable and in compliance with chapter 440, Fla. Stat.
9. List any limitations on authorization. For example, we recommend: “The carrier will not reimburse any practitioner dispensed medications without specific, prior written agreement as to the type, strength, and quantity of such medication.” We recommend that any such authorizations consider an agreement on the price of such medication, or whether such medication bills must be processed through a Pharmacy Benefit Program or other benefit manager. Additionally, we recommend language to the effect: “Authorization of the provider does not include authorization of subsequently recommended treatment plans without express authorization from the carrier.”
10. Authorization for treatment is a condition precedent to payment. See, section 440.13(3)(a), Fla. Stat., and failure to obtain authorization is basis for payment disallowance.
11. Failure to respond to request for authorization within 3 business days leads to waiving medical necessity of the referral for evaluation, but not to waiver of the medical necessity of subsequently recommended treatment.
12. The carrier controls authorization, unless they fail to respond and provide treatment, and claimant thereafter seeks authorization from the JCC for medically necessary and causally related care.
13. **Excessive Billing Amounts Charged by Medical Providers**
14. Review Division Schedules for Provider’s maximum Reimbursement Amount. Not all treatments have a MRA. If no MRA, contact the provider to negotiate a commercially reasonable payment amount. Note that the Division is Promulgating a large number of new MRAs for Outpatient hospital and ASC treatment. If adopted, these new MRAs will reduce the number of “price” based disputes where no MRA previously existed. The Division is also promulgating a new, three-tiered per diem reimbursement methodology for inpatient hospital bills.
15. Have technical bill review by professionals to verify, through a standard bill review process, whether a facility or other large bill is appropriately considered a “clean bill” before it is considered ripe for payment. This involves review to confirm that all treatment was ordered by a physician, medically necessary, therapeutically appropriate, actually provided and reviewed for unbundling, including supplies that should be “baked into” a surgical charge or the use of inappropriate billing codes, modifiers, or pricing for a particular service. Such bill review for a “clean bill” should be made before any negotiation or payment of a significant bill is undertaken.
16. Ensure that large bills and designated fee schedules are consistent with the law, e.g., see *Zenith Insurance Co. v. Department of Financial Services*, Division of Workers’ Compensation DOAH Case No. 18-3844 (Recommended Order May 8, 2019) concerning large inpatient hospital bills. There is a question as to whether this ruling will be adopted by the Division of Workers’ Compensation in light of the fact that the Division adopted an alternate per diem rate.
17. All bill review entities or carriers have access to benchmarking data through Medispan Drug Data Base, Health Care Blue Book, Optum, Fair Health, All-Claims Payer databases, Medicare, Red Book etc., as well as Reimbursement Manuals with similar procedures or treatment often containing an MRA or “fee schedule.”
18. **Medical Care Providers Prescribing and Dispensing Medications**
19. §440.13, F.S., provides that injured workers have the right to select their own pharmacy for the dispensing of prescribed medications.
20. Certain doctors and practitioners are allowed to dispense medications from their offices, §465.0276, F.S.
21. Division of Workers’ Compensation Informational Bulletin DWC-01-2020 dated March 31, 2020.
22. In the Matter of Todd Alea, M.D., Case No.: 122698-WC. Final Order August 3, 2012.
23. If a prescription bill is submitted by a third party agency, obtain a contract or similar document setting forth the authority of the third party to collect medication costs on behalf of the dispensing party.
24. Proposed Rule 69L-7.740 forbids carriers from ever adjusting a bill for medications based on a lack of authorization.
25. DWC began issuing Determinations of Reimbursement Disputes in July, 2021 finding that carrier may not refuse to authorize practitioner dispensed medication, apparently based on the policy set forth in Bulletin DWC-01-2020. On May 16, 2022, a group of carriers filed a Petition Requesting an Administrative Law Judge at DOAH to Invalidate this Unadopted Agency Rule and Policy in DOAH Case No.: 22-1472RU. On July 12, 2022, The DWC rescinded that Bulletin, and agreed to initiate rulemaking on the details of practitioner dispensing. The Division’s official position is not yet clear, but in their November 1, 2022 Rule workshop, they suggested that they may still presume that a carrier may not refuse to authorize practitioner dispensing, but industry representatives presented a unified voice in opposition to that position.
26. **Jurisdiction**

Issues often arise relating to whether the Judge of Compensation Claims has jurisdiction to decide medical controversies or whether the decision should be made administratively by the Division of Workers’ Compensation. JCC assumption of jurisdiction brings with it the possibility of an award of attorney fees whereas in administrative proceedings, attorney fee awards are awardable in only extremely rare circumstances. Oftentimes, the Division does not have the needed manpower or inclination to get heavily involved in deciding medical issues, understanding that data shows that medical issues are the number one subject that is most litigated in workers’ compensation matters. If the Employer/Carrier engages in a pattern or practice of arbitrarily or unreasonably disallowing or reducing payments, attorney’s fees can be awardable. *Orange County v. Willis*, 996 So. 2d 870 (Fla. 1st DCA 2008).

It is important to remember that, because Workers’ Compensation is a Legislative Creation, the respective jurisdiction of the JCC and the Division must be clearly determined by the written statute. One cannot assume any jurisdiction beyond what is specified in the Law. The following is a list of issues over which the Division assumes jurisdiction and those issues that the JCC assumes jurisdiction:

1. **Division of Workers’ Compensation Jurisdiction**
2. Litigation between the carrier and provider as to the amount of a doctor’s bill that should be paid.
3. Dispute must be between the employer/carrier and the medical provider and not between the employer/carrier and claimant. (Claimant has no standing to file claim for the payment of doctor’s bill where dispute is over the amount of the bill. J.B.D. Brothers and Masonry, Inc. v. Miranda, 25 So. 3d 1271.) Atlantic Foundation v. Gurlacz, 582 So. 2d 10 (Fla. 1st DCA 1991); Miami Corp v. Freshwater, 599 So. 2d 674 (Fla 1st DCA 1992) (en banc); Lamounette et al v. Elwyn Akins, 547 So. 2d 1001(1st DCA 1989); Terners of Miami Corp. V. M. Felix Freshwater, 599 So. 2d 674 (Fla. 1st DCA 1992); Orange County, Florida v. Willis, 996 So. 2d 870 (Fla. 1st DCA 2008; §440.13(1)(4), Florida Statutes.
4. The dispute is related to authorized medical care for which the claimant is not liable. Platzek v. Rock-a-Way, Inc., 512 So. 2d 233(Fla 1st DCA 1995); Long Grove Builders v. Haun, 508 So. 2d 476(Fla. 1st DCA 1987); The Avalon Center v. Hardaway, 967 So. 2d 268 (Fla 1st DCA 2007).
5. The dispute must relate to specific billings for care that has been provided and not future medical care. Furtick v. William Shults Contractors, supra;

Carswell v. Broderick Construction, 583 So. 2d 803(Fla. 1st DCA 1991); Williams v. Triple J. Enterprises, 650 So. 2d 1114. (See infra re: ability to claim for reimbursements of past medical bills.)

1. **Judge of Compensation Claims Jurisdiction**
2. The issue relates to the continued medical need and causation of future medical services including deauthorization of medical care. Wolk v. Jaylen Homes, Inc., 593 So. 2d 1058 (Fla. 1st DCA 1992); Furtick v. William Shults Contractor, supra; Beasly v. M & E Pieco, 678 So. 2d 519 (Fla. 1st DCA 1996).

1. Claimant seeking recoupment of monies personally expended for medical care or where claimant is responsible for such treatment. Williams v. Triple J. Enterprises, 650 So. 2d 1114 (Fla. 1st DCA 1995).

1. Compensability of accident issues. Furtick v. William Shults Contractor, supra.

1. Causal Connection issues. Furtick v. William Shults Contractor, supra.

1. “Medical Necessity” for the need for further treatment. See #1 above.

(see also #2 above) - Tiznado v. Orlando Regional Healthcare System, 773 So. 2d 584 (Fla 1st DCA 2000); Beasley v. M & E Pieco, 678 So. 2d 519 (Fla 1st DCA 1996); School Board of Manatee County v. Chrisman, 678 So. 2d 498 (Fla. 1st DCA 1996).

1. Diagnosis issues – *Furtick v. William Shults Contractor*, supra.
2. Medical status of claimant issues. Carswell v. Broderick Construction, 583 So. 2d 803 (Fla. 1st DCA 1991); Furtick v. William Shults Contractor, supra.
3. Failure of Employer/Carrier to follow Utilization Review (UR) procedures. Wolk v. Jaylen Homes, Inc., 593 So. 2d 1058(Fla. 1st DCA 1992). However, if the carrier has followed UR procedures, disallowance of payment and overutilization proceeding falls within Division’s exclusive jurisdiction.

1. **Outlier Cases**- There are a number of outlier cases which arise, typically because a claimant files a Petition asking the JCC to “order authorization and payment” in a certain amount to a specific provider.
2. If the carrier has not authorized treatment, the JCC can review whether authorization should be ordered, but the underlying payment amount remains within the exclusive jurisdiction of the Division pursuant to s.440.13(7), Fla. Stat.
3. If a provider ‘balance bills’ the claimant, but the carrier timely authorizes the treatment, the JCC does not have jurisdiction. If, for example, a hospital or radiology facility provided emergency treatment, or if a provider did not know that the service was for a compensable workers’ compensation claim, the provider should be notified that the claim is compensable, the treatment is authorized, and the where the bills should be sent for administrative review and adjustment pursuant to Rule 69L-7.730, FAC. The Provider may not balance bill the injured worker for compensable (and non-apportioned), authorized treatment.
4. If a provider continues to balance bill an injured worker for authorized, compensable care, the provider may be referred to the Division for Provider violations under 69L-34, FAC. Additionally, the Florida Supreme Court recently held that a provider who knowingly violates the s.440.13(3)(f), Fla. Stat. by billing the injured worker for a compensable, authorized service, may be liable to the injured worker for civil damages and attorney’s fees under the **Florida Consumer Collection Practices Act (FCCPA)**. See, Laboratory Corporation of America, et al. v. Davis, S.Ct. Case No: 19-1936 (May 26, 2022).
5. **Utilization of Medical Treatment (Overutilization of Medical Care)**
6. §440.13(2), F.S., requires carriers to have in place a system of utilization control to review all proposed care plans. This plan should be in writing. As a part of the Division’s audit process, a determination as to whether such exists and if not, penalties/fines will be assessed.
7. The employer/carrier must accept any proposed course of treatment as recommended by the authorized doctor unless notification is given to the authorized physician of its specific objections to the proposed course of treatment by the close of the 10th business day after notification by the physician or a supervised designee of the physician, of the proposed course of treatment.
8. Evaluation of proposed treatment plans to resolve questions about medical necessity, therapeutic alternatives, side effects and causal relationship to the original injury include (see definition of Utilization Review, §440.13(1)(s), F.S.):
9. Peer Review
10. Physician Review by carrier’s medical director
11. IME
12. Dispute Resolutions Over Jurisdiction Concerning Overutilization
13. Referral of provider for pattern or practice of overutilization/audit §440.13(8) & (11), F.S.
14. Writ of Mandamus does not apply requiring Division to review. §440.08(8)(b), F.S. *City of Hollywood v. Benoit*, supra.
15. Return of past payments or if provider does not refund overutilized payments once ordered within 30 days, assessment of penalties. §440.08(8)(b), F.S.
16. JCC continues to play a role in utilization disputes even though no Petition for Benefits has been filed. *Delgado v. J.C. Concrete*, 72 So. 2d 353 (Fla. 1st DCA 1998). For example, the JCC can require the claimant to:
17. Compel/Attend IME - §440.13(5)(a), F.S.
18. Require claimant to pay 50% of physician’s cancellation fee for IME No-Show. §440.13(5)d), F.S.
19. Dispute Resolution over Jurisdiction – JCC Attempts to Assume Jurisdiction of Overutilization Determination.

a. Motion to Dismiss for Lack of Subject Matter Jurisdiction

b. Appeal

1. Interlocutory Appeal - Fla. R. App. P. 9.180(b)(1) - Review of non-final orders that adjudicate jurisdiction. Delgado v. J.C. Concrete, supra.

2. Writ of Prohibition Lamounette et al Elwyn Akins, supra; Atlantic Foundation v. Gurlacz

3. Division of Workers’ Compensation fails to timely decide overutilization issue

a. Writ of Mandamus - City of Hollywood v. Benoit 830 So. 2d 254 (Fla. 1st DCA 2002)

4. Request for Administrative Hearing §120.57, Florida Statutes - see above.