From:	wrabb@workcompcentral.com
To:	Open Government
Cc:	Galetta, Devin
Subject:	Records request on written comments on 69L-31
Date:	Wednesday, January 8, 2020 1:53:40 PM
Attachments:	WCC Pic2 (smallest) (1).png

I would like to request a copy of the written comments provided on Proposed Rule Chapter 69L-31, FAC, Utilization and Reimbursement Dispute Rules, as referenced here: https://www.flrules.org/gateway/View_Notice.asp?id=22641466

The public comment period was from 11/22/2019 to 12/13/2019.

I am happy to pay any reasonable copying and administrative fees regarding this request. I can accept these records in electronic form, via email, to wrabb@workcompcentral.com.

Thanks for your assistance.

William Rabb
WorkCompCentral.com
850-512-4327

From: Christine Sensenig
To: Pugh, Theresa
Subject: [EXTERNAL] Rule 69L-31.002-.013 Comments
Date: Monday, December 23, 2019 10:25:39 PM
Attachments: 69L-31.002-5 CRS Edits.pdf

Theresa,

I will attend the Public Hearing scheduled for January 8, 2020 on the proposed revisions to Rule 69L-31.002-.013 to share for the public record my written comments attached to this email.

Happy Holidays to you and your family!

Thank you,

Chris
Christine Sensenig, Esquire
Hultman Sensenig + Joshi
2055 Wood Street, Suite 208
Sarasota, FL 34237
(941) 953-2828
(941) 953-3018 (fax)

http://senseniglawfirm.wordpress.com

Notice of Proposed Rule

DEPARTMENT OF FINANCIAL SERVICES
Division of Workers' Compensation
RULE NOS.:RULE TITLES:
69L-31.002 Definitions
69L-31.003 Petition Form
69L-31.004 Carrier Response Form
69L-31.005 Petition Requirements
69L-31.006 Consolidation of Petitions
69L-31.007 Service of Petition on Carrier and Affected Parties
69L-31.008 Computation of Time
69L-31.009 Carrier Response Requirements
69L-31.010 Effect of Non-Response by Carrier
69L-31.011 Complete Record
69L-31.012 Joint Stipulation of the Parties
69L-31.013 Petition Withdrawal
69L-31.014 Overutilization Issues Raised in Reimbursement Dispute Resolution
PURPOSE AND EFFECT: The Department proposes rule amendments to clarify requirements and procedures for resolution of medical reimbursement disputes.
SUMMARY: Modification of the processes related to resolution of reimbursement disputes by the Florida Department of Financial Services pursuant to section 440.13(7)(e), F.S.
SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS AND LEGISLATIVE RATIFICATION:
The Agency has determined that this will not have an adverse impact on small business or likely increase directly or indirectly regulatory costs in excess of $200,000 in the aggregate within one year after the implementation of the rule. A SERC has not been prepared by the Agency.
The Agency has determined that the proposed rule is not expected to require legislative ratification based on the statement of estimated regulatory costs or if no SERC is required, the information expressly relied upon and described herein: A preliminary economic analysis conducted by the Department indicated that the proposed rules will not have an adverse impact or result in regulatory costs in excess of $1 million within five years, as established in section 120.541(2)(a), F.S.
Any person who wishes to provide information regarding a statement of estimated regulatory costs, or provide a proposal for a lower cost regulatory alternative must do so in writing within 21 days of this notice.
RULEMAKING AUTHORITY: 440.13(7), (7)(e), 440.591, FS.
LAW IMPLEMENTED: 440.13(7), (9), (11), FS.
A HEARING WILL BE HELD AT THE DATE, TIME AND PLACE SHOWN BELOW:
DATE AND TIME: Wednesday, January 8, 2020, 9:30 a.m. Eastern Time
PLACE: Room 155, 1579 Summit Lake Drive, Tallahassee, FL 32317
Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least 5 days before the workshop/meeting by contacting: Theresa Pugh, telephone: (850)413-1721, email: Theresa.Pugh@myfloridacfo.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice). If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).
THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Theresa Pugh, Program Administrator – Medical Services Section, Bureau of Monitoring and Auditing (please see contact information in paragraph above).

THE FULL TEXT OF THE PROPOSED RULE IS:

69L-31.002 Definitions.

The definitions that follow and those in section 440.13(1), F.S., apply to capitalized terms used in this rule chapter:

(1) "Notice of Disallowance or Adjustment" means a document that identifies the amount of disallowance or adjustment of payment that corresponds with the medical bill submitted by the Health Care Provider;

(2) "Petitioner" means the Health Care Provider, or entity acting on behalf of the Health Care Provider, submitting a Petition Form to contest Carrier disallowance or adjustment of payment.

(3) "Petition Form" means the Petition for Resolution of Reimbursement Dispute Form, DFS-F6-DWC-3160-0023, incorporated in Rule 69L-31.003, F.A.C.

(4) "Response Form" means the Carrier Response to Petition for Resolution of Reimbursement Dispute Form, DFS-F6-DWC 3160-0024, incorporated in Rule 69L-31.004, F.A.C.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7) FS. History–New.

69L-31.003 Petition for Resolution of Reimbursement Dispute Form and Requirements.

(1) The Petition for Resolution of Reimbursement Dispute Form, DFS-F6-DWC-3160-0023, revised MM/YYYY, ~~(DFS Form 3160-0023, effective September 8, 2006)~~ is ~~hereby~~ incorporated by reference herein. This form may be obtained on the Department's website ~~Internet~~ at https://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm ~~http://www.myfloridacfo.com/wc/forms.html~~ or by contacting the Department at (850)413-1613.

(2) A petition to contest Cearrier disallowance or adjustment of payment pursuant to section 440.13(7)(a), F.S., must be made on the Petition ~~for Resolution of Reimbursement Dispute~~ Form. The Department will not accept any other form or document in lieu of the Petition Form. Instructions for submission of the Petition Form are included on the bottom of the Petition Form. ~~Any submission seeking to contest the disallowance or adjustment of payment by a carrier pursuant to section 440.13(7)(a), F.S., must include a completed Petition for Resolution of Reimbursement Dispute Form.~~

(3) The Petitioner must submit the Petition Form to the Department within the timeframe set forth in section 440.13(7)(a), F.S., and must include with the Petition Form the documents listed below that support the allegations contained in the Petition Form:

(a) A copy of each Notice of Disallowance or Adjustment received from the Carrier and, if applicable, proof of the date of receipt, as required by subsection 69L-31.008(1), F.A.C.;

(b) A copy of all medical bill(s) or request(s) for reimbursement sent to the Carrier for which payment was disallowed or adjusted by the Carrier on each Notice of Disallowance or Adjustment;

(c) A copy of all documentation submitted to the Carrier in support of the medical service(s), bill(s), or request(s) for reimbursement that are subject to the dispute;

(d) A copy of all documentation submitted to the Health Care Provider and/or Facility establishing the customary rate or area comparative rate accepted as payment by similar providers in the same geographic region.

(~~cd~~) If the services in the Notice of Disallowance or Adjustment were provided pursuant to a contract, documentation substantiating the contract was in effect for the line item(s) in dispute and the provision which governs reimbursement for the services but only if the entire contract is in the possession of the carrier or carrier's designee;

(~~de~~) If the Medical Necessity of the services in the Notice of Disallowance or Adjustment are being disputed, any relevant section(s) of evidence-based practice guidelines the Petitioner relied upon to support the Medical Necessity of the services in the contested line item(s) (in the absence of, or deviation from, the evidence-based practice guidelines, the Petitioner may provide a signed document from the Health Care Provider who provided the services in the contested line item(s) in the Notice of Disallowance or Adjustment describing the Medical Necessity of the services);

(~~ef~~) If the authorization for the services in the Notice of Disallowance or Adjustment are being disputed, all of the Petitioner's documentation, records, and correspondence related to the authorization or request for authorization; and

(~~fg~~) Any additional documents or records that support the allegations contained in the Petition Form.

(4) If the Petitioner does not submit a completed Petition Form, accompanied by all of the required items, the Department will notify the Petitioner of the deficiency in submission. The Petitioner will have twenty (20) calendar

days from receipt of the notice of deficiency to cure the deficiency by providing to the Department the items specified in the Department's notice along with proof of proper service of the curative documentation upon the Carrier. If the Department does not receive the curative documentation and proof of service of the curative documentation upon the Carrier within twenty (20) calendar days after Petitioner's receipt of the notice of deficiency, the petition will be dismissed with prejudice.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7) ~~440.13(7)(a)~~, 440.13(11) FS. History–New 11-28-06, Formerly 59A-31.003, Amended .

69L-31.004 Carrier Response to Petition for Resolution of Reimbursement Dispute Form and Requirements.

(1) The Carrier Response to Petition for Resolution of Reimbursement Dispute Form, DFS-F6-DWC-3160-0024, revised MM/YYYY, ~~(DFS Form 3160-0024, effective September 8, 2006)~~ is ~~hereby~~ incorporated by reference herein. This form may be obtained on the Department's website ~~Internet~~ at https://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm ~~http://www.myfloridacfo.com/wc/forms.html~~ or by contacting the Department at (850)413-1613.

(2) ~~The Carrier Response to Petition for Resolution of Reimbursement Dispute Form shall be considered a required element of the requested documentation to the Department under section 440.13(7)(b), F.S.~~ The ~~Carrier~~ Response ~~to Petition for Resolution of Reimbursement Dispute~~ Form is ~~shall be~~ the only form accepted by the Department upon which a Cearrier may submit ~~to the Department~~ its response, pursuant to section 440.13(7)(b), F.S., to a Petition Form ~~for Resolution of Reimbursement Dispute~~. Instructions for submission of the Response Form are included on the bottom of the Response Form.

(3) The Carrier must submit the Response Form, accompanied by all supporting documentation, to the Department in accordance with the timeframe set forth in section 440.13(7)(b), F.S.

(a) Such supporting documentation must include additional information establishing the customary rate or area comparative rate accepted as payment by similar providers in the same geographic region. This additional information, redacted to protect patient privacy, shall include but not be limited to information about payments made and accepted in the same geographic area by providers for the same or substantially similar services.

(b) If EOBR code 10 or 11 (used to deny payment because the service rendered is for a non-compensable injury or illness) was used as a reason to deny payment for the line item(s) the Petitioner contends was improperly denied, a copy of the Form DFS-F2-DWC-12, Notice of Denial, adopted in Rule 69L-3.025, F.A.C., that was sent to the injured worker and Health Care Provider pursuant to Rule 69L-56.4012, F.AC., must be included as part of the supporting documentation.

(c~~b~~) If the Carrier relied upon evidence-based practice guidelines to support the disallowance of payment for the Medical Necessity of services in the Notice of Disallowance or Adjustment, the Carrier may submit the relevant section(s) of the evidence-based practice guidelines, along with a signed document from the Carrier's medical director confirming that the relevant section(s) of the evidence-based practice guidelines is the reason for the disallowance or adjustment of payment. Absent any relevant section(s) of evidence-based practice guidelines, the Carrier may provide a Peer Review to support the disallowance of payment for the Medical Necessity of services in the contested line item(s) in the Notice of Disallowance or Adjustment.

(de) If the Carrier disallowed or adjusted the payment in the Notice of Disallowance or Adjustment because the Petitioner was not authorized to provide the services, all of the Carrier's documentation, correspondence, and records evidencing authorization was not given to the Health Care Provider prior to the dates of service(s) or all of the Carrier's documentation, records, and correspondence evidencing the Carrier responded to the request for authorization in accordance with paragraphs (3)(d) or (3)(i) of section 440.13, F.S.

(4) Using a delivery method that provides confirmation of the date of delivery, the Carrier must provide to the Petitioner, at the Petitioner's mailing address provided on the Petition Form, a copy of the Response Form and all supporting documentation submitted to the Department in response to the Petition Form. The Carrier must document the delivery tracking information in such detail that the Department can verify the Petitioner's receipt of the Response Form and supporting documentation.

~~(5) Any submission by a Cearrier pursuant to section 440.13(7)(b), F.S., that does not include a completed Carrier Response to Petition for Resolution of Reimbursement Dispute Form, accompanied by all required items, will shall result in the issuance of a notice of deficiency by the Department. The A Cearrier will shall have twenty~~

~~(20) ten (10) calendar days from receipt of the notice of deficiency to cure the deficiency by providing to the Department the items specified in the Department's notice along with proof of proper service of the curative documentation upon the Petitioner identified in the Department's notice of deficiency. Failure to timely cure the deficiency and provide proof of service of the curative documentation upon the Petitioner will shall constitute failure to submit requested documentation to the Department.~~

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7) ~~440.13(7)(b)~~, 440.13(11) FS. History–New 11-28-06, Formerly 59A-31.004, Amended .

Comment: For proposed Rule 69L-31.005, Mitchell and Mitchell's clients continue to be frustrated with petitions that are repeatedly filed that are incomplete or fail to provide necessary information. The opportunity to cure should not be an unlimited one through the filing of additional inaccurate petitions. These inaccurate petitions cause work for OMS, for the carrier, and even for the providers - there should be a penalty for poor performance and faulty training. A Dismissal with Prejudice is the appropriate response to sloppy submissions. To ask Florida's taxpayers to bear the burden of paying State employees to repeatedly "fix" the petitions filed by private for-profit entities is simply asking too much.

Substantial rewording of Rule 69L-31.005 follows. See Florida Administrative Code for present text.

69L-31.005 Written Determinations ~~Petition Requirements~~.

(1) The Department will render a written determination on whether the Carrier properly adjusted or disallowed payment by relying upon the applicable reimbursement schedules, practice parameters, protocols of treatment, **regional average billing rates for substantially similar procedures.** and standards and policies set forth in chapter 440, F.S. (and the rules promulgated therefrom), along with the Petition Form, ~~and~~ Response Form, and all supporting documentation submitted to the Department by the Petitioner and the Carrier to support their respective positions. The Department will use an Expert Medical Advisor, in accordance with section 440.13(9)(b), F.S., to resolve Reimbursement Disputes associated with the disallowance or adjustment of payment based upon: 1) overutilization; or 2) Medical Necessity of the services in the Notice of Disallowance or Adjustment when both the Petitioner (pursuant to paragraph 69L-31.003(3)(e), F.A.C.) and Carrier (pursuant to paragraph 69L-31.004(3)(b), F.A.C.) have provided documentation to support their respective decisions on the Medical Necessity of the services.

(2) In its written determination, the Department will only address the specific line item(s) in the Notice of Disallowance or Adjustment that the Petitioner contends were improperly disallowed or adjusted.

(3) If the Carrier has failed to meet the requirement set forth in paragraph 69L-31.004(3)(a), F.A.C., the Department, in its written determination, will only address the specific line item(s) in the Notice of Disallowance or Adjustment that the Petitioner contends were improperly denied.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7), 440.13(9), 440.13(11) FS. History–New 11-28-06, Formerly 59A-31.005, Amended .

69L-31.006 Consolidation of Petitions.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7)(e) FS. History–New 11-28-06, Formerly 59A-31.006, Repealed.

69L-31.007 Service of Petition on Carrier and All Affected Parties.

(1) The Ppetitioner must ~~shall~~ effectuate service on ~~upon~~ the Cearrier and on all affected parties by serving a copy of the Ppetition Form, and all supporting documentation submitted to the Department ~~documents and records in support of the petition~~, by United States Postal Services (USPS) certified mail on the specific entity identified on the Notice of Disallowance or Adjustment ~~Explanation of Bill Review~~ as the entity the Cearrier designates to receive service of the Petition Form and all supporting documentation on behalf of the Cearrier and all affected parties. ~~If the Explanation of Bill Review does not specifically identify the name and mailing address of the entity the carrier~~

~~designates to receive service on behalf of the carrier and all affected parties, as required by paragraph 69L-7.602(5)(q), F.A.C., the petitioner may effectuate service of the petition upon the carrier and all affected parties by serving a copy of the petition and copies of all documents and records in support of the petition by United States Postal Service (USPS) certified mail upon the entity who issued the Explanation of Bill Review at the address from which the Explanation of Bill Review was issued.~~

~~(2) A Petition for Resolution of Reimbursement Dispute must be served upon the carrier and all affected parties by United States Postal Service (USPS) certified mail. Service upon the carrier shall include one copy set of all documents and records submitted to the Department in support of the petition.~~

~~(3) Service by certified mail means service by United States Postal Service (USPS) certified mail.~~ Service by ~~United States Postal Service~~ (USPS) delivery other than USPS certified mail or service by common carrier does not constitute service by USPS certified mail, as required by section 440.13(7)(a), F.S., ~~statute,~~ even if the Carrier's ~~carrier delivery and~~ receipt of the documents is ~~petition are~~ confirmed.

(2) ~~(4)~~ If a Ccarrier has not been properly served in accordance with this rule ~~subsection~~, the Ppetitioner will be notified by the Department of the deficiency in service. The Ppetitioner will ~~shall~~ have ten (10) calendar days from receipt of the notice of deficiency in service to provide the Department with proof the deficiency in service identified in the notice of deficiency has been cured by proper service. If the Department does not receive proof of proper service within ten (10) calendar days after Ppetitioner's receipt of the notice of deficiency, the petition will be dismissed with prejudice. For purposes of this rule, "proof of proper service" means that a copy of the Ppetition Form, and all supporting documentation submitted to the Department, ~~one copy set of all documents and records in support of the petition~~ have been sent by ~~United States Postal Service~~ (USPS) certified mail to the proper entity at the proper address as set forth in this rule~~,~~ and a certified mail receipt number is provided to the Department to confirm mailing.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7) ~~440.13(7)(a)~~, 440.13(11) FS. History–New 11-28-06, Formerly 59A-31.007, Amended .

Substantial rewording of Rule 69L-31.008 follows. See Florida Administrative Code for present text.

69L-31.008 Computation of Time.

(1)(a) The forty-five (45) day time period within which a Petition Form must be submitted to the Department begins upon receipt of the Notice of Disallowance or Adjustment by the Health Care Provider or by an entity designated by the Health Care Provider to receive such notice on behalf of the Health Care Provider.

(b) The Health Care Provider must document receipt of the Notice of Disallowance or Adjustment by either: 1) using a date stamp that clearly reflects the date of receipt of the Notice of Disallowance or Adjustment by the Health Care Provider; or 2) using a verifiable login process. A date-stamped Notice of Disallowance or Adjustment will be accepted as proof of the date of receipt. A copy of the applicable portion of the login roster showing the date of login of the Notice of Disallowance or Adjustment will be accepted as proof of the date of receipt through a verifiable login process.

(c) If receipt cannot be established through a date stamp or verifiable login process, the Petitioner may provide a copy of the envelope in which the Notice of Disallowance or Adjustment was sent that clearly and legibly shows the postmark date, in which case receipt will be deemed to be five (5) calendar days after the postmark date.

(d) If the Petitioner does not establish the date of its receipt of the Notice of Disallowance or Adjustment by any of the methods set forth in this subsection through documentation accompanying the Petition Form, the Health Care Provider's receipt of the Notice of Disallowance or Adjustment will be deemed to be five (5) calendar days after the issue date on the Notice of Disallowance or Adjustment. An affidavit attesting to the date of receipt will not be accepted as proof of the date of receipt.

(2) Petitioning the Department to resolve a Reimbursement Dispute is effectuated upon submission of the Petition Form and supporting documentation to the Department. The timeliness of a Petition Form will be calculated based on the date of submission of the Petition Form to the Department in accordance with subsection (4), below.

(3) The thirty (30) day time period within which a Response Form must be submitted to the Department begins upon the date the Carrier receives the Petition Form, which will be established by the USPS certified mail receipt date. If the Department issues a notice of deficiency to the Petitioner, then the thirty (30) day time period within which a Response Form must be submitted to the Department begins upon the date the Carrier receives the curative

documentation, which will be established by the USPS certified mail receipt date. Timely submission by the Carrier to the Department of the Response Form and supporting documentation will be determined based on the date of submission of the Response Form and supporting documentation to the Department in accordance with subsection (4), below.

(4) Submission of a Petition Form or Response Form to the Department must be by USPS mail, by common carrier, or by hand delivery. If submission is by USPS mail, the date of submission to the Department will be the postmark date placed on the envelope by USPS. If submission is by common carrier, the date of submission to the Department will be the common carrier pick-up date. If submission is by hand delivery, the date of submission will be the date the Petition Form or Response Form is hand delivered to the receptionist at the hand delivery address listed on the forms (which can only be accomplished Monday through Friday, between 8:00 a.m. and 5:00 p.m., Eastern Time, excluding state of Florida holidays).

(5) Time periods established for petitioning the Department to resolve a Reimbursement Dispute or responding to a Petition Form are not tolled by any of the following actions: requesting an on-site audit; conducting an on-site audit; referral of the Health Care Provider for peer review consultation; or an independent medical examination of the injured employee.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7) ~~440.13(7)(a) and (b)~~, 440.13(11) FS. History–New 11-28-06, Formerly 59A-31.008, Amended .

69L-31.009 Carrier Response Requirements.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7)(b) FS. History–New 11-28-06, Formerly 59A-31.009, Repealed .

69L-31.010 Effect of Non-Response by Carrier.

Rulemaking Authority 440.13(7), 440.591 FS. Law Implemented 440.13(7)(b) FS. History–New 11-28-06, Formerly 59A-31.010, Repealed .

69L-31.011 Complete Record.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7)(c) FS. History–New 11-28-06, Formerly 59A-31.011, Repealed .

69L-31.012 Joint Stipulation of the Parties.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7) FS. History–New 11-28-06, Formerly 59A-31.012, Repealed .

69L-31.013 Petition Withdrawal.

(1) Prior to the issuance of a determination, the Ppetitioner may voluntarily withdraw its Petition Form ~~for Resolution of Reimbursement Dispute~~.

(2) The withdrawal must ~~of a petition shall~~ be in writing and must clearly indicate:

(a) The case number assigned by the Department; or

(b) The name of the Petitioner ~~health care provider or facility~~ requesting withdrawal,~~;~~ ~~(b)~~ t~~T~~he name of the Cearrier against which ~~whom~~ the Reimbursement Dispute ~~petition~~ has been initiated,~~;~~~~(c)~~ t~~T~~he date(s) of service identified on the Petition Form, ~~covered by the petition;~~ and ~~(d)~~ t~~T~~he identity of the injured employee to whom medical services were delivered.

(3) Upon the Department's ~~The result of~~ receipt ~~by the Department~~ of a written request for withdrawal of a Petition Form, the Department will close its file on the matter, with prejudice, without further action ~~petition shall be dismissal of the determination case by the Department~~.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7) ~~440.13(7)(a) and, (c)~~, 440.13(11) FS. History–New 11-28-06, Formerly 59A-31.013, Amended .

69L-31.014 Overutilization Issues Raised in Reimbursement Dispute Resolution.

Rulemaking Authority 440.13(7)(e), 440.591 FS. Law Implemented 440.13(7)(b) and (c), FS. History–New 11-28-06, Formerly 59A-31.014, Repealed .

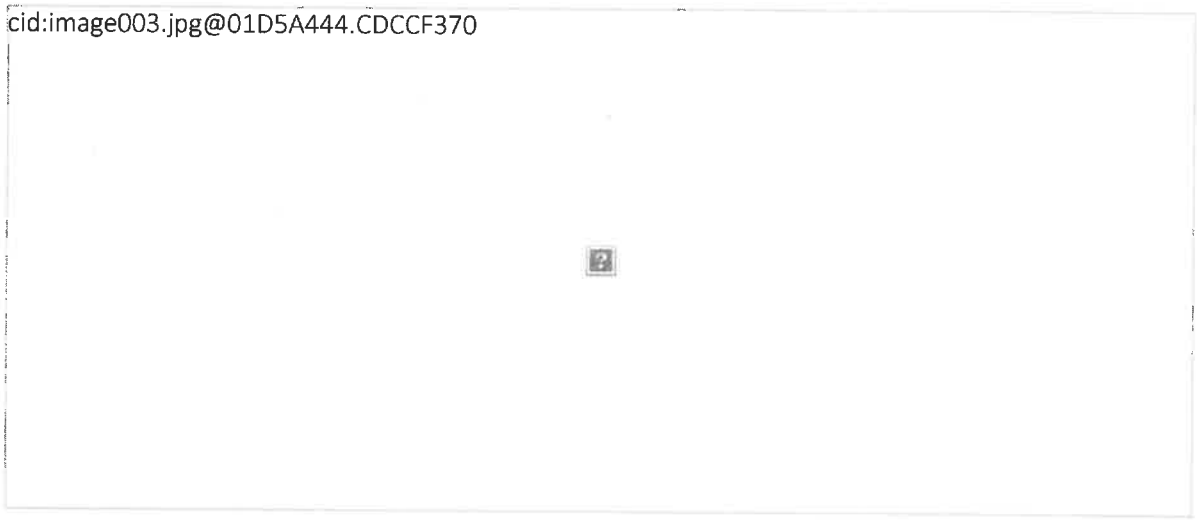
NAME OF PERSON ORIGINATING PROPOSED RULE: Andrew Sabolic
NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: CFO Jimmy Patronis
DATE PROPOSED RULE APPROVED BY AGENCY HEAD: November 21, 2019
DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAR: November 21, 2019

From:	Chakita Jenkins
To:	Pugh, Theresa
Cc:	Virginia Dailey; Nemecek, Thomas; Smith, Robin; Marino, Leah; Humphrey, Keith
Subject:	Proposed Changes to Rule Chapter 69L-31, Fla. Admin. Code
Date:	Friday, December 13, 2019 2:49:44 PM
Attachments:	Letter to DFS on November 2019 Proposed Rule (00786818xCEE20).pdf

Good Afternoon Ms. Pugh,

On behalf of Ms. Virginia Dailey, Counsel for Automated Health Care Solutions, Inc. and Prescription Partners, LLC, please find the attached correspondence in regards to the above-referenced subject. The original has been mailed out to you today as well. Should you have any questions or concerns, Ms. Dailey has been copied on this email as well.

Thank you and Have a nice day,



PANZAMAURER

FORT LAUDERDALE
Coastal Towers | Suite 905
2400 East Commercial Boulevard
Fort Lauderdale, Florida 33308
(954) 390-0100 Fax (954) 390-7991

Please reply to Fort Lauderdale Office

December 13, 2019

Theresa.Pugh@myfloridacfo.com
Ms. Theresa Pugh
Florida Department of Financial Services
Division of Workers' Compensation
Hartman Building
2012 Capital Circle SE
Tallahassee, FL 32301

RE: Proposed Changes to Rule Chapter 69L-31, Fla. Admin. Code

Dear Ms. Pugh:

On behalf of Automated Healthcare Solutions ("AHCS"), also doing business as Prescription Partners, please allow this document to serve as written comments to be included in the record of the rulemaking process pertaining to the proposed changes to Rule Chapter 69L-31, Fla. Admin. Code, which were publicly noticed on November 22, 2019 in the Florida Administrative Register, and in advance of the public hearing scheduled for January 8, 2020. AHCS appreciates the Division's efforts to revise the rules and looks forward to working with the Division on these revisions moving forward.

FINANCIAL IMPACT OF PROPOSED RULE

While AHCS has not yet determined the precise financial impact of the proposed rules on its business operations, AHCS anticipates the rules – in their currently proposed form – would have a substantial financial impact on its business operations.

AHCS anticipates that the proposed rules will lead to a significant increased number of non-payments of claims by carriers, requiring an equally significant number of petitions for reimbursement dispute resolution to be filed with the Division, and the potential for further action in front of DOAH related to the outcome of those petitions and the impact of the proposed rules. AHCS believes that, under the currently proposed rules, the cost of non-payment or underpayment of claims, the costs associated with preparing and filing petitions for resolution of reimbursement dispute, and the costs associated with pursuing further relief related to those reimbursement disputes, will remain high and impose a substantial burden on the business operations of AHCS and other similarly-situated entities.

AHCS disputes the Division's determination that the proposed rule will not have adverse impact on small business or increase regulatory costs in excess of $200,000 in the aggregate within one year after its implementation. AHCS requests the Division to prepare a Statement of Estimated Regulatory Costs (SERC) of the proposed rule.[1]

LOWER COST REGULATORY ALTERNATIVES

AHCS is proposing by separate letter several lower cost regulatory alternatives to the Division's proposed rules.

EOBR vs. NOTICE OF DISALLOWANCE

Proposed Rule 69L-31.002(1) adds a definition of the term "Notice of Disallowance or Adjustment" to mean "a document that identifies the amount of disallowance or adjustment of payment that corresponds with the medical bill submitted by the Health Care Provider." This change is similar to changes that the Division has previously proposed in rule language or Reimbursement Manual language. As previously set forth in our letters of December 4, 2018, August 22, 2018, March 5, 2018, January 13, 2017, June 20, 2016, and January 25, 2016, AHCS strongly objects to this change. The Division should maintain the clear statutory and rule requirement that the EOBR is the ONLY document through which a carrier may provide notice of disallowance or adjustment of payment. See, e.g.:

- Rule 69L-7.740(14), F.A.C. (Carrier "acting on behalf of the insurer to pay, adjust, disallow or deny a filed bill shall send to the health care provider an EOBR detailing the adjudication of the submitted bill by line item, utilizing only the EOBR codes and code descriptors per line item, as set forth in subsection 69L-7.740(13), F.A.C., and shall include the insurer name, Division issued insurer code number and corresponding insurer mailing address. .... A claim administrator or any entity acting on behalf of the insurer shall notify the health care provider of notice of payment or notice of adjustment, disallowance or denial **only through an EOBR**. An EOBR shall specifically state that the EOBR constitutes notice of disallowance or adjustment of payment within the meaning of subsection 440.13(7), F.S. ...") (emphasis added);
- Rule 69L-7.710(1)(y), F.A.C. ("'Explanation of Bill Review' (EOBR) means **the** document used to provide notice of payment or notice of adjustment, disallowance or denial by a [carrier] to a health care provider containing code(s) and code descriptor(s), in conformance with subsection 69L-7.740(13), F.A.C.") (emphasis added);
- Rule 69L-7.740(6), F.A.C. ("An Insurer shall be responsible for accurately completing required data filed with the Division ..."); ("accurately complete" means "the form submitted contains the information necessary to meet the requirements of chapter 440, F.S., and this rule", 69L-7.710(1)a), F.A.C.); and

[1] See Florida Association of Ambulatory Surgery Centers, et al. v. Dept. of Financial Services, Final Order, DOAH Case. No. 17-3025, Nov. 30, 2017, Conclusions of Law ##142-149 (ALJ McArthur criticized the Division's failure to prepare a SERC and reliance upon stock or check-the-box answers).

- Rule 69L-7.740(1), F.A.C. ("An insurer is responsible for meeting its obligations under this rule …."); and
- Rule 69L-7.740(11), F.A.C. ("An insurer … shall comply as indicated below to ensure the timely and correct reimbursement of properly completed medical bills…"); and
- Sub-section 440.13(13)(a), Fla. Stat. ("Carriers shall pay, disallow, or deny payment to health care providers in the manner and at times set forth in this chapter.").[2]

Similarly, the remainder of the proposed rule includes several references to "Notice of Disallowance or Adjustment" rather than "EOBR." AHCS believes this term should be rejected, and the term "EOBR" retained in all instances. For example, proposed Rule 69L-31.003(3)(a) requires a Petition Form to include "each Notice of Disallowance or Adjustment received from the carrier." This term should be rejected in favor of keeping the existing language in Rule 69L-31.005(1)(a): the Petition Form must include "each Explanation of Bill Review received from the carrier providing notice of disallowance or adjustment of payment in this dispute."

AHCS often suffers delays in receiving reimbursement due to carriers sending an untimely EOBR or denials/ disallowances through an incomplete EOBR. Indeed, AHCS has submitted numerous Petitions for Resolution of Reimbursement Dispute to the Division in which the carriers have filed incomplete or untimely EOBRs.[3] In each of these cases, the Division has dismissed AHCS' petitions because they are allegedly not yet ripe due to the carriers' failure to submit a complete EOBR. AHCS is disputing these determinations/ dismissals, and is seeking an administrative hearing of these reimbursement disputes.[4] AHCS believes the carriers are obligated by Chapter

---

[2] Several other statutory and rule provisions support this framework. See, e.g., sub-section 440.20(2)(b), Fla. Stat. ("The carrier must pay, disallow, or deny all medical, dental, pharmacy, and hospital bills submitted to the carrier in accordance with department rule no later than 45 calendar days after the carrier's receipt of the bill.") and 440.20(6)(b), F.S. (department shall impose penalties for late disallowances of payment); sub-section 440.13(16), Fla. Stat. ("Failure to comply with [section 440.13] shall be considered a violation of [Chapter 440, Fla. Stat.] and is subject to penalties…"); sub-section 440.13(2)(e), Fla. Stat. (in order to object to a proposed course of treatment, insurer must notify physician of its specific objections to the proposed course of treatment by the close of the 10th business day after notification by the physician of the proposed course of treatment); Rule 69L-7.020(1), F.A.C. (Health Care Provider Reimbursement Manual establishes reimbursement policies, guidelines and codes for services and supplies provided by health care providers); Rule 69L-7.740(11)(f), F.A.C. ("insurer may return medical bill without issuance of an EOBR only on the basis of the deficiency criteria in 69L.7.740(11)(g)4.-7. [employee information is illegible or incorrect]); Rule 69L-7.740(12), F.A.C. (carrier "shall pay, adjust, disallow or deny billed charges within 45 days from the 'Date Insurer Received Bill,' pursuant to paragraph 440.20(2)(b), F.S."); Rule 69L-7.750(11), F.A.C. (insurer shall submit to the Division the EOBR codes relating to adjudication of each line item billed, and maintain EOBR in format that can be legibly reproduced, and shall comply with EOBR instructions in 69L-7.740(13), F.A.C.); and current Rule 69L-31.008(1), F.A.C. (30-day time period for health care provider to file Petition for Reimbursement Dispute Determination begins "upon receipt of the EOBR").

[3] See, e.g., MSS Cases Nos. 20190314-019, 20190419-021, 20190418-002, 20181217-015, 20181218-022, 20190125-024, 20181228-013, 20181120-035, 20181023-026, 20181016-039, 20190107-015, 20190226-020, 20181016-036, 20181016-029, 20181205-018, 20190425-008, 20190212-025, 2019-415-032, 20181203-024, 20190128-041, 20181002-005, 20190212-028, 20190213-019, and 20190328-021, and 20180426-012.

[4] See, e.g., DOAH Cases No. 19-6001/ 19-6003, 19-6141, 19-6144, 19-6384, 19-6383, 19-6413, 19-6521, and 19-6526.

440, F.S., and Rules 69L-7 and 69L-31, F.A.C., to provide timely and complete EOBRs to the providers, and that the carriers should be held accountable for their violation of those statutory and regulatory obligations. AHCS believes the Division is unfairly burdening the petitioners due to actions beyond the petitioners' control.

The Division has in previous statements indicated that expanding the definition of "EOBR" to include a "notice of disallowance" could redress such delays or incomplete EOBRs from carriers. However, AHCS believes just the opposite is likely to occur. Carriers' ability to submit a "notice of disallowance" without the required elements of an EOBR will cause additional confusion and delay in the workers' compensation system. Further, the proposed rule will reward (or at least fail to punish) carriers for violating Rules 69L-7.710 and 69L-7.740, F.A.C., by failing to timely submit the required elements of an EOBR.

Further, the proposed rule is the wrong procedural path to make this change. If the Division wishes to make changes in the process for carriers to review medical bills, the Division must make such changes within Rule Chapter 69L-7, F.A.C. The Division's attempts to make these changes through a side door (in Chapter 69L-31) are incomplete and illogical.

Moreover, AHCS is aware of no legislative or other regulatory change that creates authority or need for this proposed rule change.

Finally, this proposed rule would be inconsistent with several of the Division's previous workers' compensation reimbursement dispute determinations. Following are just a few examples. In OMS Case No. 20120202-007 (*In the Matter of: Dr. Richard Rozencwaig v. Hartford Fire Insurance Company,* for injured employee: J. Carrillo, Date-of-Injury: 04/27/2008, Date-of-Service: 02/01/2011), the carrier submitted an inaccurate/ incomplete EOBR. The Division allowed the petition to proceed to a determination despite the inaccurate/ incomplete EOBR, and the Division's Amended Reimbursement Dispute Determination found that the workers' compensation rules "stipulate[] the appropriate EOBR codes that must be used when explaining to the provider the carrier's reimbursement decisions. The EOBR fails to comply with the coding requirements of the rule; thus, the OMS finds the carrier failed to substantiate its reimbursement adjustments on the EOBR." In OMS Case No. 20120725-099 (*In the Matter of: Dr. Robert W. Fleigelman, M.S., vs. City of Hollywood,* for injured employee: J. Castillo, Date-of-Injury: 10/05/2010, Date-of-Service: 11/09/2010), the Division's Reimbursement Dispute Determination found that the carrier's EOBR was "non-compliant" and lacked certain required elements", but nevertheless found that the petition was timely served on the Division and the carrier, and proceeded to make a determination in the dispute. In MSS Case No. 20180426-012 (*In the Matter of: Dr. Kornberg vs.Old Republic Insurance Company,* for injured employee: C. Chang, Date-of-Injury: 10/3/2017, Date-of-Service: 1/31/2018), the Division initially dismissed AHCS' petition because the carrier issued a "remittance report" disallowance certain reimbursements but not an EOBR. After AHCS filed a Petition for Administrative Hearing in this case, and settlement discussions with the Division, the Division issued a revised Determination on August 15, 2018 agreeing that the petition "met the filing requirements", and rejecting the carrier's grounds for disallowance and ordering carrier to pay the disallowed amount. Subsequently, the carrier paid the full requested amount, and AHCS withdrew its petition. (See DFS Final Order in DFS Case #229976-WC, dated Sep. 9, 2019.) If

the problem is the carrier's failure to submit a complete, timely and accurate EOBR in response to a medical bill, the Division's "solution" is misguided. Instead, the Division should focus on the rules as they relate to the carrier – because an EOBR is entirely and solely within the control of the carrier, not the provider.

Instead of the Division's 2019 Proposed Rule, AHCS suggests consideration of the previously-proposed rule provision (69L-31.016) offered in 2018 by the Division. In the Division's February 16, 2018 Notice of Development of Rulemaking, as well as previous drafts of the proposed rule, proposed rule 69L-31.016 makes clear that a carrier's failure to provide payment and/or an EOBR within 45 days of receipt of the medical bill is an "improper reimbursement practice", which can subject the carrier to administrative penalties and fines in accordance with Section 440.13(7)(f), F.S., or Rule 69L-24.007, F.A.C. AHCS supports that proposed rule language as part of the dispute resolution rules. While many carriers operate in good faith under Chapter 440, there are certain carriers who routinely and intentionally flout Chapter 440 and the corresponding rules. AHCS believes the Division has the authority to ensure carriers are engaging in billing and reimbursement practices properly, and believes that the formerly proposed 69L-31.016 could be an important mechanism for the Division to engage in enforcement of Chapter 440 and the rules relating to billing and reimbursement. Former proposed rule 69L-31.016 incentivizes carriers to submit timely, accurate, and complete EOBRs. However, if no changes are made at all, i.e., if former proposed rule 69L-31.016 is not adopted, the Division has the authority hold carriers accountable for their violations of Chapter 440 and the corresponding rules. Sections 440.13(6) and 440.20(6)(b), Fla. Stat., and Rule 69L-7, F.A.C., provide the Division with the authority to issue Reimbursement Determinations where the carrier fails to submit a complete or timely EOBR.

Proposed Rule 69L-31.007(1) requires the Notice of Disallowance (or EOBR) to specify who should receive service of any petition for reimbursement dispute determination, but the rule does not provide who should receive service in the event that the Notice of Disallowance (or EOBR) does not so specify. There should be a default provision of where the petition must be sent if it is not specified on the Notice of Disallowance (or EOBR).

MEDICAL NECESSITY

The Department proposes in Rules 69L-31.003(3)(e) that, if a carrier disputes the medical necessity of a line item, a provider must document the medical necessity of the disputed line item with (a) "evidence-based practice guidelines the Petitioner relied upon to suggest the Medical Necessity of the services in the contested line item(s)" or (b) a signed document from the provider describing the medical necessity of the services in the absence of or deviation from the evidence-based practice guidelines. Typically, the Petitioner provides a "Letter of Medical Necessity" (signed by the authorized physician who has evaluated and treated the patient) or medical notes or records with its Petition Form when the carrier disputes the medical necessity of a medication. AHCS believes that medical notes, medical records, or a Letter of Medical Necessity should be one pathway for a provider to submit documentation describing the medical necessity; AHCS

would like to clarify this, because it is not clear whether such a medical note, record, or Letter of Medical Necessity will satisfy the requirements of the proposed rule.

The current rules include an embedded presumption that the authorized treating physician's prescribed course of treatment is medically necessary. The current framework puts the burden of challenging/ disputing medical necessity of a particular treatment on the carrier. See 440.13(6), Fla. Stat. (carriers review bills and disallow payment where "the carrier determines that a provider did not comply with practice parameters and protocols in providing the treatment rendered"); Rule 69L-7.740(13)(b) (EOBR codes 23, 24, 25). The proposed rule removes that presumption by allowing a carrier to dispute medical necessity by simply submitting practice guidelines with no patient-specific determination by a physician of the medical necessity of the prescribed course of treatment. In practice, this proposed rule makes its easy (and low-cost or no-cost) for carriers to dispute medical necessity, and shifts the burden to the health care provider to document the medical necessity of each and every patient's course of treatment beyond what is customary. For example, a physician typically records medical notes for a patient's visit and/or prepares a Letter of Medical Necessity. AHCS wishes to clarify that either medical notes or a Letter of Medical Necessity would be sufficient to satisfy the requirement of the proposed rule. Otherwise, the proposed rule seems to undermine the Legislature's intended self-executing and efficient nature of the workers' compensation system and to create both economic and administrative burdens that are unnecessary to the system. See Section 440.015, Fla. Stat.

Further, the Department has attempted to avoid issuing determinations where a carrier disputes the medical necessity of a particular line item for several years. AHCS has provided comments on various previous proposals, and reiterates those concerns here. AHCS appreciates the inclusion in the Proposed Rule of a requirement that the carrier involve a medical professional in its medical necessity decisions; AHCS proposes that the rule be further revised to require that the carrier's "medical director" be a licensed physician in the same specialty as that of the authorized treating physician.

AUTHORIZATION

Proposed Rule 69L-31.003(3)(f) and 69L-31.004(3)(c) both require providers and carriers to provide "all of the Petitioner's documentation … related to the authorization or request for authorization", or, evidence that "authorization was not given", respectively. Similar authorization language is included on both the proposed Petition Form and Carrier Response Form. This is contrary to the statutory and regulatory framework which provides three pathways to authorization: written authorization, verbal authorization, and default authorization (when the carrier fails to timely respond to a provider's request for authorization). Imposing a requirement of written documentation will lead to significant additional cost in medical reimbursement disputes to providers, carriers, and the Division and will thwart the Legislature's intent for a self-executing and efficient system.

There is no need for this proposed rule. The current regulatory scheme provides the parties with the obligations and opportunities necessary to request and/or respond to a request for authorization. Carriers have multiple pathways to provide or deny authorization. The Division should proceed to issue reimbursement dispute determinations using the current statutory and rule framework, as it has done in previous reimbursement dispute determinations, even when the carrier disputes authorization. See, e.g., MSS Case #20160209-004, in which the Division issued a Reimbursement Dispute Determination on March 16, 2016 rejecting a carrier's disallowance based on lack of authorization (Code 30) because the carrier did not provide correspondence to support the lack of authorization.

The current rule language is not the problem; the Department's interpretation of the rule language is the problem. The Department is interpreting the statutes and rules to allow the carrier to assert lack of authorization without any evidence or documentation to support the assertion, and to trump the documentation of a request for authorization from the provider. AHCS has submitted numerous Petitions for Resolution of Reimbursement Dispute to the Division in which the carriers have asserted lack of authorization.[5] In each of these cases, the Division has dismissed AHCS' petitions based on the carrier's assertion of lack of authorization – even where the provider has documented a request for authorization and the carrier has failed to document a response to the request for authorization. AHCS is disputing these determinations, and is seeking an administrative hearing of these reimbursement disputes.[6] AHCS believes the providers have three pathways to authorization (written authorization, verbal authorization, and default authorization by failure to respond to request for authorization). The Division's interpretation (and the proposed rules) allow the carrier to assert lack of authorization without requiring the carrier to document its assertions.

The issue of authorization has long been a concern for the Division. At least since 2015, the Division has proposed statutory and/or rule changes to address this issue, including addressing the issue in the Biennial Reports of the Three-Member Panel to the Legislature. However, in each instance, the Legislature has declined to adopt the Division's proposals. Thus, the Department should not be allowed to accomplish, via rulemaking, measures the Legislature has considered and rejected.

Further, the proposed rule is not consistent with Section 440.13(3)(d), F.S. (allowing default authorization where carrier fails to respond to request for authorization), nor the language in the "Workers Compensation System Guide" published by the Division in September 2019 on its website:

> A health care provider must get authorization from the [carrier] before providing medical care to an injured worker, or payment may be denied. The DFS-F5-DWC-25 form is the required document that health care providers must use to request authorization for treatment. .... The [carrier] must respond to authorization requests for treatment by the end of the third business day after receiving a request, or within

[5] See, e.g., MSS Cases Nos. 20190305-024, 20190506-017, 20190311-025, 20190422-025, 20190129-018, 20190205-018, 20181029-012, and 20180807-018.
[6] See, e.g., DOAH Cases No. 19-5429, 19-5430, 19-6384, 19-6383, 19-6413, 19-6521, and 19-6526.

10 days for bills exceeding $1,000 pursuant to Section 440.13(3)(i), F.S. A [carrier's] failure to respond to a written request for authorization within 3 or 10 business days, as required by statute, will constitute authorization.[7]

NOTICE OF DENIAL

Proposed Rule 69L-31.004(3)(a) requests the carrier to submit a copy of the Notice of Denial (Form DWC-12) sent to the injured worker and provider, pursuant to 69L-56.4012, if the carrier denies or disallows payment based on non-compensability (EOBR code 10 or 11). AHCS has questions about how this process is intended to work. A Notice of Denial is typically used only for a full denial, and not for partial denial of benefits. In contrast, carriers often use EOBR code 10 or 11 for partial denial, i.e., to deny compensability of one medication/ treatment of injury while approving reimbursement of other medications/ treatment of injuries. See, e.g., Rule 69L-3.025.

CARRIER'S FAILURE TO RESPOND WAIVES ALL OBJECTIONS TO PETITION

Section 440.13(7)(b), F.S., provides that a carrier's failure to timely respond to a petition by submitting the necessary documentation "constitutes a waiver of all objections to the petition." Proposed Rule 69L-31.004(5) provides that the carrier's failure to cure any deficiencies in its Carrier Response will "constitute failure to submit requested documentation to the Department." In accordance with section 440.13(7)(b), AHCS believes that the carrier's failure to submit documentation should result in waiver of the carrier's objections to the petition, thus resulting in the Division's issuance of a Determination accepting the assertions of petition. Proposed Rule 69L-31.005(3) could be inconsistent with Section 440.13(7)(b) because it appears to allow the Division to reject assertions of the petition, even where the carrier has "failed to meet the [documentation] requirements" and thus has waived all objections to the petition. AHCS requests clarification of the purpose of this proposed rule.

EVIDENCE-BASED PRACTICE GUIDELINES

AHCS is concerned with the term "evidence-based practice guidelines" in Rules 69L-31.003(3)(e) and 69L-31.004(3)(b). This term is not consistent with the term used in Section 440.13(14), F.S. ("practice parameters and protocols"). Further, the statutory reference in Section 440.13(14) is obsolete. (See Three Member Panel Biennial Report of October 2019, pg. 23.) Section 440.13(14), F.S., establishes the "practice parameters and protocols mandated under this [workers compensation] chapter" to be those protocols adopted by the US Agency for Healthcare Research and Quality in effect on January 1, 2003. This reference is now obsolete because this clearinghouse was defunded in 2016. The proposed rule is adding a reference to an obsolete statutory provision, and should be rejected. If the proposed rule is adopted, it will likely result in administrative litigation to clarify the "practice guidelines" that are referenced in the rule. The proposed rule is

[7] DFS Workers' Compensation System Guide, Revised September 2019, pg. 15, available at: https://myfloridacfo.com/Division/WC/pdf/WC-System-Guide.pdf

the wrong way to resolve this issue. The appropriate resolution is a statutory revision to address the problems with Section 440.13(14), F.S. Adopting rule language with an obsolete reference is illogical and would result in costly administrative litigation to resolve.

RESPONSE TO NOTICE OF DEFICIENCY

AHCS wishes to clarify the Petitioner's deadline to respond to a Notice of Deficiency. Proposed Rule 69L-31.003(4) gives the Petitioner twenty days from receipt of a Notice of Deficiency to cure the deficiency. In contrast, Proposed Rule 69L-31.007(2) gives the Petitioner ten days from receipt of a Notice of Deficiency to provide the Department with proof the deficiency in service has been cured. AHCS recommends the time-period for all responses to a Notice of Deficiency should be twenty days.

CONCLUSION

AHCS appreciates the opportunity to provide comments on the proposed revisions to Chapter 69L-31, F.A.C. We look forward to working with the Division on these comments. We would be happy to provide additional information or address any questions you may have about these comments at your convenience.

Sincerely,

/s/Virginia C. Dailey

VIRGINIA C. DAILEY, ESQ.
PANZA MAURER & MAYNARD, P.A.
Attorneys for Automated Health Care Solutions, Inc. and Prescription Partners, LLC

cc: Thomas Nemecek
Keith Humphrey
Robin Smith
Leah Marino

From:	Chakita Jenkins
To:	Pugh, Theresa
Cc:	Virginia Dailey; Nemecek, Thomas; Humphrey, Keith; Smith, Robin; Marino, Leah
Subject:	Lower Cost Regulatory Alternatives Chapter 69L-31, Fla. Admin. Code
Date:	Friday, December 13, 2019 2:33:25 PM
Attachments:	Letter to DFS with Lower Cost Regulatory Alternative for 69L-31 (00786819xCEE20).pdf

Good Afternoon Ms. Pugh,

On behalf of Ms. Virginia Dailey, Counsel for Automated Health Care Solutions, Inc. and Prescription Partners, LLC, please find the attached correspondence in regards to the above-referenced subject. The original has been mailed out to you today as well. Should you have any questions or concerns, Ms. Dailey has been copied on this email as well.

Thank you and Have a nice day,

cid:image003.jpg@01D5A444.CDCCF370

PANZAMAURER

FORT LAUDERDALE
Coastal Towers | Suite 905
2400 East Commercial Boulevard
Fort Lauderdale, Florida 33308
(954) 390-0100 Fax (954) 390-7991

Please reply to Fort Lauderdale Office

December 13, 2019

Theresa.Pugh@myfloridacfo.com
Ms. Theresa Pugh
Florida Department of Financial Services
Division of Workers' Compensation
Hartman Building
2012 Capital Circle SE
Tallahassee, FL 32301

RE: Lower Cost Regulatory Alternatives
Chapter 69L-31, Fla. Admin. Code

Dear Ms. Pugh:

I am writing on behalf of Automated Healthcare Solutions ("AHCS"), also doing business as Prescription Partners, which handles revenue cycle services for health care providers in Florida. AHCS respectfully proposes the following Lower Cost Regulatory Alternatives to the changes proposed in the Division's November 22, 2019 Notice of Proposed Rule for Chapter 69L-31, Florida Administrative Code.

According to the Division's Annual Report to the Three-Member Panel for Fiscal Year 2017-2018,[1] in 89% of all Reimbursement Dispute Determinations issued, the carrier underpaid the health care provider. This number grew from 79.5% in FY 2016-2017 to almost 90% in FY 2017-2018[2] – a concerning trend in carriers' handling of health care providers' requests for reimbursements. Carriers' underpayment of health care providers' reimbursement requests has been a consistent concern among health care providers and their agents, including AHCS, for many years. The Division's proposed changes to Rule Chapter 69L-31 will incentivize carriers to increase underpayments and delay timely responses and payments, which will further increase the already-substantial cost and difficulty of obtaining reimbursements.

[1] Report to the Three Member Panel Regarding the Resolution of Medical Reimbursement Disputes and Actions Pursuant to Subsection 440.13(12)(e), Florida Statutes, for Fiscal Year 2017-2018 (dated February 2019), pg. 4.
[2] Report to the Three Member Panel Regarding the Resolution of Medical Reimbursement Disputes and Actions Pursuant to Subsection 440.13(12)(e), Florida Statutes, for Fiscal Year 2016-2017 (dated February 2018), pg. 4.

AHCS submits these Lower Cost Regulatory Alternatives in accordance with Section 120.541(1)(a), Fla. Stat., as good faith written alternatives to the proposed rule which substantially accomplish the Division's statutory objectives.

(1) Proposed Rule 69L-31.002(1): Notice of Disallowance

Proposed Rule 69L-31.002(1) proposes a new defined term "Notice of Disallowance or Adjustment" that creates a new and expanded point of entry for a health care provider to file a petition for resolution of reimbursement dispute. This proposed term also appears in Rules 69L-31.003, 69L-31.004, 69L-31.005, 69L-31.007, 69L-31.008. This proposal is likely to cause confusion and delay in the reimbursement dispute process. This proposal will allow (and possibly incentivize) carriers to submit incomplete responses to requests for reimbursements, will increase health care provider costs to collect underpayments, and will add to the workload of health care providers and the Division to resolve disputes. The Proposed Rule absolves carriers of their obligation to issue timely and complete EOBRs. AHCS estimates that the requirement in the Proposed Rule to allow a Notice of Disallowance rather than requiring an EOBR will have a substantial annual cost impact to AHCS (and similarly-situated entities) as follows, *inter alia*:

- Additional time and effort to request an EOBR and/or Notice of Disallowance from the carrier, and/or to request more detail (such as EOBR codes/ reasons for disallowance) not included in a Notice of Disallowance; and
- Additional time and effort to submit Petitions for Resolution of Reimbursement Disputes to the Division and/or respond to Notices of Deficiency from the Division due to incomplete information in a Notice of Disallowance.

This proposal reduces the quick, efficient, self-executing nature of the workers' compensation system in conflict with the Legislature's intent. See Section 440.015, Fla. Stat.

AHCS proposes that the most appropriate Lower Cost Regulatory Alternative to Proposed Rule 69L-31.002(1) is to not adopt the proposed rule. There is no need for this proposed rule. The objectives of the workers' compensation law are already achieved at lower cost under the current regulatory scheme. Carriers are already required to provide timely, complete and accurate EOBRs within 45 days after receipt of a medical bill. If carriers comply with the system, the EOBR provides all of the information necessary for the provider to understand the reasons for the disallowance and for the Division to determine a reimbursement dispute. Carriers should bear the consequences of failing to comply with these obligations; such consequences should not be imposed on the petitioner, which has no control or ability to obtain a timely, accurate or complete EOBR. AHCS typically submits a petition for resolution of reimbursement dispute after receipt of the carrier's EOBR (whether or not it includes all required elements of an EOBR). The Division should proceed with such petitions to a determination using the current statutory and rule framework, as it has done in previous reimbursement dispute determinations, even when the

carrier's EOBR was non-compliant or lacked certain required elements. See, e.g., MSS Cases Nos. 20120202-007, 20120725-099, and 20180426-012.

(2) Proposed Rule 69L-31.005(1): Medical Necessity/ Expert Medical Advisor

Proposed Rule 69L-31.005(1), F.A.C., requires the Division to use an Expert Medical Advisor (EMA) if the carrier disallows or denies reimbursement based on medical necessity and both the petitioner and carrier provide documentation to support their respective decisions on the medical necessity of the disputed line item(s). This creates a significant additional expense to the Division for all medical necessity disputes, when an EMA may be required in only a few such disputes. Further, the Division already has authority to utilize an EMA where necessary, pursuant to Section 440.13(9), F.S., and thus the proposed rule is unnecessary.

AHCS proposes that the most appropriate Lower Cost Regulatory Alternative to Proposed Rule 69L-31.005(1) is to not adopt the proposed rule.

(3) Proposed Rules 69L-31.003(3)(f) and 69L-31.004(3)(c): Authorization

Proposed Rules 69L-31.003(3)(f) and 69L-31.004(3)(c) both require providers and carriers to provide "all of the Petitioner's documentation … related to the authorization or request for authorization", or, evidence that "authorization was not given", respectively. This is contrary to the statutory and regulatory framework which provides three pathways to authorization: written authorization, verbal authorization, and default authorization (when the carrier fails to timely respond to a provider's request for authorization). Imposing a requirement of written documentation will lead to significant additional costs in medical reimbursement disputes for providers, carriers, and the Division and will thwart the Legislature's intent for a self-executing and efficient system. AHCS estimates that the proposed rule will result in the following substantial increased costs for its own operations (and for those of similarly-situated entities):

- Additional time and effort to request authorization – and to document such requests even though they are statutorily authorized to include verbal authorization
- Impracticality of proving a negative. When the provider sends the DWC25 as a request for authorization, and the carrier fails to timely respond, the burden of documenting the carrier's response to the request for authorization should fall on the carrier, not the provider. The absence of documentation in the provider's records of a carrier's response to the request for authorization should be sufficient to demonstrate that the carrier failed to timely respond to a request for authorization. Proposed Rule will result in additional time and effort for the provider to address carriers' failure to respond to requests for authorization; and
- Additional time and effort to submit Petitions for Resolution of Reimbursement Disputes to the Division and/or respond to Notices of Deficiency from the Division due to incomplete documentation of authorization. The carrier should bear the burden to

demonstrate that it denied authorization (or timely responded to the request for authorization) in order to disallow based on lack of authorization.

AHCS proposes that the most appropriate Lower Cost Regulatory Alternative to Proposed Rule 69L-31.003(f) and 69L-31.004(3)(c) is to not adopt the proposed rule. There is no need for this proposed rule. The objectives of the workers' compensation law are already achieved at lower cost under the current regulatory scheme. Carriers have multiple pathways to provide or deny authorization. The Division should proceed to issue reimbursement dispute determinations using the current statutory and rule framework, as it has done in previous reimbursement dispute determinations, even when the carrier disputes authorization. See, e.g., MSS Case #20160209-004, in which the Division issued a Reimbursement Dispute Determination on March 16, 2016 rejecting a carrier's disallowance based on lack of authorization (Code 30) because the carrier did not provide documentation to support the lack of authorization.

(4) Proposed Rules 69L-31.004(4), 69L-31.007, 69L-31.008(4): Service by Certified Mail

Proposed Rule 69L-31.004(4), 69L-31.007, and 69L-31.008(4) continue to require service of documents by certified US mail. AHCS believes that service by email (with a "read receipt") would accomplish the same objectives for substantially less cost for all parties, and recommends the adoption of rules allowing such service for all documents in the medical billing and reimbursement dispute process. AHCS proposes that the most appropriate Lower Cost Regulatory Alternative to Proposed Rules 69L-31.004(4), 69L-31.007, and 69L-31.008(4) is to develop rule language that allows service amongst all parties in the medical billing and reimbursement dispute process (the Division, the providers, and the carriers) by email, with acknowledgements or receipts to provide necessary documentation.

Further, the delivery method requirements should be of equivalent cost for both providers and carriers. AHCS recommends that the rule be revised to require all carriers authorized in the Florida workers' compensation system to designate an email address for all disputes, to be filed and updated annually with the Division.

(5) Proposed Rule 69L-31.003(3)(e): Practice Parameters and Protocols

Proposed Rule 69L-31.003(3)(e) proposes that the petitioner must provide documentation of "evidence-based practice guidelines" relied upon by the health care provider "to support the Medical Necessity of the services in the contested line item(s)." This requirement is also referenced in Proposed Rule 69L-31.004(3)(b), for carriers to provide such documentation if the carrier relied upon such guidelines in making a medical necessity decision. Section 440.13(14), F.S., establishes the "practice parameters and protocols mandated under this [workers compensation] chapter" to be those protocols adopted by the US Agency for Healthcare Research and Quality in effect on January 1, 2003. This reference is now obsolete because this clearinghouse was defunded in 2016. The proposed rule is adding a reference to an obsolete statutory provision, and should be rejected. If the proposed rule is adopted, it will likely result in confusion and delay in determining what

"evidence-based practice guidelines" fall within the Division's proposed rule, and potentially to administrative litigation to clarify the "practice guidelines" that are referenced in the rule. There is no need for this proposed rule. The appropriate resolution is a statutory revision to address the problems with Section 440.13(14), F.S. Adopting rule language with an obsolete reference is illogical and would result in confusion, delay, and possibly costly administrative litigation to resolve.

Further, the proposed rule's new requirement to document "practice guidelines" with any medical bill in which the medical necessity of the line item(s) is disputed incentivizes the carrier to dispute medical necessity in all reimbursement disputes. The carrier will bear no additional cost or burden to make such an assertion, while such an assertion will trigger a burden on the provider to document the "practice guidelines" associated with the disputed line item(s). The proposed rule will thus add significant burden of time and expense to health care providers to gather and document "practice guidelines" for particular patients, particular injuries or conditions, and particular courses of treatment. AHCS estimates that the requirement in proposed rule 69L-31.003(3)(e) to provide documentation of "practice guidelines" will have a substantial annual cost impact to AHCS, and the health care providers it represents, including the subscription costs of medical guidelines databases as well as the staff time and effort to document guidelines for each particular patient and date-of-service. Such patient-specific details should only be required when there is a credible basis to question the authorized treating physician's diagnosis and treatment of the injured worker.

AHCS proposes that the most appropriate Lower Cost Regulatory Alternative to Proposed Rule 69L-31.003(3)(e) is to not adopt the proposed rule.

Thank you for your consideration.

/s/Virginia C. Dailey

VIRGINIA C. DAILEY, ESQ.
PANZA MAURER & MAYNARD, P.A.
Attorneys for Automated Health Care Solutions, Inc.
and Prescription Partners, LLC

cc: Thomas Nemecek
Keith Humphrey
Robin Smith
Leah Marino