

STATEWIDE PROVIDER AND HEALTH PLAN CLAIM DISPUTE RESOLUTION PROGRAM

Annual Report February 2011

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Pursuant to the provisions of section 408.7057, Florida Statutes (F.S.), the Agency for Health Care Administration (Agency) is required to submit a report to the Governor and the Legislature by February 1 of each year on the status of the Statewide Provider and Health Plan Claim Dispute Resolution Program. Section 408.7057(2) (g) 2., F.S., specifically requires the report to enumerate claims dismissed, defaults issued, and failures to comply with Agency final orders issued under this section.

Program Description

The Statewide Provider and Health Plan Claim Dispute Resolution Program was established by the 2000 Florida Legislature to provide assistance to contracted and non-contracted providers and managed care organizations for resolution of claim disputes that are not resolved by the provider and the managed care organization. The statutes required the Agency to contract with a resolution organization to timely review and consider claim disputes and to submit its recommendation to the Agency. The Agency's responsibility is to issue a final order adopting the recommendation of the resolution organization.

After adopting rules necessary to implement the program (59A-12.030, Florida Administrative Code), the Agency issued a "Request for Proposals", and entered into a contract with Maximus, Inc. to review claim disputes. Maximus has been reviewing claim disputes since March 2001.

Maximus operates a toll-free hotline (1-866-763-6395) to provide information and dispute application forms to interested parties. The cost of the program is borne by users of the dispute program. The entity that does not prevail in the Agency's final order must pay the review cost. In cases where both parties prevail in part, the review cost must be shared. The review costs are determined by Maximus and depend largely on the complexity of the cases submitted.

Initially the program was designed to resolve only disputes between providers, health maintenance organizations, prepaid health clinics and exclusive provider organizations. In 2002, the Legislature expanded the program to include other insurers offering major medical expense insurance policies and preferred provider organizations. The revised law also strengthened the ability of the resolution organization to enforce review timeframes and the timely submission of information requested. The types of claims eligible under this program are further defined in rule consistent with statutory provisions.

Eligible Claims:

The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed health care providers, Health Maintenance Organizations (HMOs), Prepaid Health Plans, Exclusive Provider Organizations (EPOs), major medical expense health insurance policies offered by a group or an individual health insurer, and preferred provider organizations.

- Claim disputes for services rendered after October 1, 2000 (the effective date of the initial legislation).
- Claim disputes related to payment amounts only (provider dispute payment amounts received or disputed payback amounts). Claim disputes exclusively related to late payment are not eligible but are handled by the Office of Insurance Regulation.
- Hospitals and physicians are required to aggregate claims by type of service to meet certain thresholds:

- Hospital Inpatient Claims (contracted providers)	\$25,000
- Hospital Inpatient Claims (non-contracted providers)	\$10,000
- Hospital Outpatient Claims (contracted providers)	\$10,000
- Hospital Outpatient Claims (non-contracted providers)	\$ 3,000
- Physicians	\$ 500
- Rural Hospitals	None
- Other Providers	None

Ineligible Claims:

- Claim disputes that are subject to state/federal court action.
- Claim disputes that are subject to an internal binding managed care organization resolution process for contracts entered prior to October 1, 2000.
- Late payment disputes.
- Interest payment disputes.
- Medicare claim disputes.
- Medicaid claim disputes that are subject to fair hearings.
- Other non-state regulated health plans.

Program Caseload

No data is available to determine if the number of claim disputes statewide declined, or if providers are going directly to the court system to litigate their disputes. However, since inception of the program, the number of cases reviewed has ranged from a low of 15 in 2007 to a high of 174/175 in 2004/2005.

Thirty-seven (37) cases were submitted to Maximus in 2010 (see chart on p. 5 re: last four bullets below).

- Five providers submitted incomplete information and the cases were returned;
- Three cases were not accepted by Maximus because the cases did not meet the eligibility requirements;
- Ten cases were withdrawn by Maximus because the case was not within its jurisdiction;
- Two cases were withdrawn at the provider's request;
- Four cases were accepted for full review and are still pending;
- Two cases completed the review process and a final order is still pending; and
- Eleven cases completed the review process and a final order was issued.

Claim disputes were filed by hospitals, practitioners, institutions and other licensed health care providers.

These disputes involved Aetna US Healthcare, Amerigroup of Florida, Blue Cross/Blue Shield of Florida, CarePlus, CIGNA Healthcare, HealthEase, Humana and United Healthcare.

Claim dispute amounts filed ranged from a low of \$165.00 to a high of \$67,500.00. Each claim dispute generally represents several aggregated claims.

Review fees ranged from a low of \$50.00 to a high of \$593.75.

Eligible Claims Accepted for Review

Case Number	Provider Name	Respondent	Disputed Amount	Awarded Amount
FL10-0001*	Outpatient Surgery Center of St. Augustine	Blue Cross Blue Shield	\$5,630.00	\$0
FL10-0002	Corey H. Henderson, MD	HealthEase	\$1,280.00	\$1,280.00
FL10-0003	Infectious Disease Consultants	Amerigroup	\$700.00	\$700.00
FL10-0009	Outpatient Surgery Center of St. Augustine	Blue Cross Blue Shield	\$5,832.00	\$4,612.48
FL10-0010	West Coast Anesthesiology Associates	Aetna	\$6,144.50	\$6,144.50
FL10-0013	Leon Egozi, MD	Humana	\$1,957.62	\$1,957.62
FL10-0014	Leon Egozi, MD	Humana	\$2,274.55	\$2,274.55
FL10-0015	Samer Jundi, MD	Blue Cross Blue Shield	\$6,385.69	\$3,045.50
FL10-0016	Whole Health Chiropractic & Wellness	United	\$5,245.00	\$5,245.00
FL10-0023	Outpatient Surgery Center of St. Augustine	Blue Cross Blue Shield	\$4,607.44	\$4,607.44
FL10-0025	Outpatient Surgery Center of St. Augustine	Blue Cross Blue Shield	\$5,866.90	Pending
FL10-0027	Outpatient Surgery Center of St. Augustine	Blue Cross Blue Shield	\$9,389.00	Pending
FL10-0030**	Whole Health Chiropractic & Wellness	United	\$2,690.00	\$2,690.00
FL10-0031**	West Orange Physicians Group	Amerigroup	\$625.00	\$625.00
FL10-0032	Outpatient Surgery Center of St. Augustine	United	\$20,260.00	Pending
FL10-0033	Outpatient Surgery Center of St. Augustine	United	\$37,850.00	Pending
FL10-0035	Outpatient Surgery Center of St. Augustine	Blue Cross Blue Shield	\$8,219.80	Withdrawn at provider's request
FL10-0036	Outpatient Surgery Center of St. Augustine	Blue Cross Blue Shield	\$19,482.00	Withdrawn at provider's request
FL10-0037	Outpatient Surgery Center of St. Augustine	United	\$18,824.01	\$18,824.01

*Not awarded to Provider.

**Final Order pending.