By Senator Grimsley

21-00273-13 20131662__

A bill to be entitled

An act relating to workers' compensation; amending s. 440.13, F.S.; prohibiting an employer or carrier from refusing to authorize a health care provider to treat an injured employee solely because the health care provider is also the dispensing practitioner; authorizing a health care provider to dispense and fill prescriptions for medicines if the health care provider who is also the dispensing practitioner receives authorization from an employer or a carrier to treat an employee; prohibiting the Department of Financial Services, an employer, or carrier from requiring the injured employee to use a specified pharmacy, pharmacist, or dispensing practitioner; deleting provisions to conform to changes made by the act; providing the reimbursement amount for prescription medications; specifying circumstances under which a provider is required to give a credit to the insurance carrier or self-insured employer for each prescription that costs more than a specified amount; providing for the deposit of the credit; requiring the department to recalculate the amount of the provider rebate; prohibiting a physician or the physician's assignee from holding an ownership interest in a licensed pharmaceutical repackaging entity or to set or cause to be set a repackaged pharmaceutical average wholesale price; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (3) and (12) of section 440.13, Florida Statutes, are amended, present subsection (17) is amended and redesignated as subsection (18), and a new subsection (17) is added to that section, to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(3) PROVIDER ELIGIBILITY; AUTHORIZATION.—

(a) As a condition for ~~to~~ eligibility for payment under this chapter, a health care provider who renders services must be a certified health care provider and must receive authorization from the carrier before providing treatment. This paragraph does not apply to emergency care. An employer or a carrier may not refuse to authorize a health care provider to treat an injured employee solely because the health care provider is also the dispensing practitioner, as defined in s. 465.0276. The department shall adopt rules to administer ~~implement~~ the certification of health care providers.

(b) A health care provider who renders emergency care shall ~~must~~ notify the carrier by the close of the third business day after it has rendered such care. If the emergency care results in admission of the employee to a health care facility, the health care provider shall ~~must~~ notify the carrier by telephone within 24 hours after initial treatment. Emergency care is not compensable under this chapter unless the injury requiring emergency care arose as a result of a work-related accident. Pursuant to chapter 395, all licensed physicians and health care providers in this state shall be required to make their services

available for emergency treatment of any employee eligible for workers' compensation benefits. To refuse to make such treatment available is cause for revocation of a license.

(c) A health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the carrier, except when emergency care is rendered. Any referral must be to a health care provider that has been certified by the department, unless the referral is for emergency treatment, and the referral must be made in accordance with practice parameters and protocols of treatment as provided for in this chapter.

(d) A carrier shall ~~must~~ respond, by telephone or in writing, to a request for authorization from an authorized health care provider by the close of the third business day after receipt of the request. A carrier who fails to respond to a written request for authorization for referral for medical treatment by the close of the third business day after receipt of the request consents to the medical necessity for such treatment. All such requests must be made to the carrier. Notice to the carrier does not include notice to the employer.

(e) Carriers shall adopt procedures for receiving, reviewing, documenting, and responding to requests for authorization. Such procedures must ~~shall~~ be for a health care provider certified under this section.

(f) By accepting payment under this chapter for treatment rendered to an injured employee, a health care provider consents to the jurisdiction of the department as provided ~~set forth~~ in subsection (11) and to the submission of all records and other information concerning such treatment to the department in

connection with a reimbursement dispute, audit, or review as provided by this section. The health care provider must further agree to comply with any decision of the department rendered under this section.

(g) The employee is not liable for payment for medical treatment or services provided pursuant to this section except as otherwise provided in this section.

(h) The provisions of s. 456.053 are applicable to referrals among health care providers, as defined in subsection (1), treating injured workers.

(i) Notwithstanding paragraph (d), a claim for specialist consultations, surgical operations, physiotherapeutic or occupational therapy procedures, X-ray examinations, or special diagnostic laboratory tests that cost more than $1,000 and other specialty services that the department identifies by rule is not valid and reimbursable unless the services have been expressly authorized by the carrier, or unless the carrier has failed to respond within 10 days to a written request for authorization, or unless emergency care is required. The insurer shall authorize such consultation or procedure unless the health care provider or facility is not authorized or certified, unless such treatment is not in accordance with practice parameters and protocols of treatment established in this chapter, or unless a judge of compensation claims has determined that the consultation or procedure is not medically necessary, not in accordance with the practice parameters and protocols of treatment established in this chapter, or otherwise not compensable under this chapter. Authorization of a treatment plan does not constitute express authorization for purposes of

this section, except to the extent the carrier provides otherwise in its authorization procedures. This paragraph does not limit the carrier's obligation to identify and disallow overutilization or billing errors.

(j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee is ~~shall be~~ entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the department, an employer, or a carrier, or any agent or representative of the department, an employer, or a carrier, to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist.

(k) If a health care provider who is also the dispensing practitioner, as defined in s. 465.0276, receives authorization from an employer or a carrier to treat an employee pursuant to paragraph (a), the health care provider may dispense and fill prescriptions for medicines under this chapter. For purposes of dispensing and filling prescriptions for medicines, the department, employer, or carrier, or an agent or representative of the department, employer, or carrier, may not select the pharmacy, pharmacist, or dispensing practitioner that the employee must use.

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(a) A three-member panel is created, consisting of the

Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, is ~~shall be~~ classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, is ~~shall be~~ classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care is ~~shall be~~ based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which may ~~shall~~ not exceed 23 hours. All compensable charges for hospital outpatient care are ~~shall be~~ reimbursed at 75 percent of usual and customary charges, except as otherwise provided by this subsection. ~~Annually,~~ The three-member panel shall annually adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program is ~~shall be~~ reimbursed ~~either~~ the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

(b) It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals are ~~shall be~~ reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure are ~~shall be~~ reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

3. Outpatient reimbursement for scheduled surgeries are ~~shall be~~ reduced from 75 percent of charges to 60 percent of charges.

4. Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 is ~~shall be~~ increased to 110 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

5. Maximum reimbursement for surgical procedures is ~~shall be~~ increased to 140 percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

~~(c) As to reimbursement for a prescription medication, the~~

~~reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No such contract shall rely on a provider that is not reasonably accessible to the employee.~~

(c) ~~(d)~~ Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, may ~~must~~ not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. In determining the uniform schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.4001, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and

4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(d) ~~(c)~~ In addition to establishing the uniform schedule of maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to evaluate the adequacy of the workers' compensation fee schedule, nationally recognized fee schedules and alternative methods of reimbursement to certified health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey certified health care providers and health care

facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 1, 2003, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel.

(17) REIMBURSEMENT FOR PRESCRIPTION MEDICATION.—The reimbursement amount for prescription medication is the average wholesale price plus $4.18 for the dispensing fee, unless the carrier and the provider seeking reimbursement have directly contracted with each other for a lower reimbursement amount.

(a) If a prescription has been repackaged or relabeled, the provider shall give a $15 credit to the insurance carrier or self-insured employer for each prescription that costs more than $25. The credit must be reflected in the Explanation of Bill

Review provided by the carrier or employer. The credit does not apply if the carrier and the provider seeking reimbursement have directly contracted with each other for a lower reimbursement amount. Any credit to a self-insured employer must be directly deposited to the self-insurance fund of the entity. Beginning July 1, 2015, and every 2 years thereafter, the Department of Financial Services shall recalculate the amount of the provider rebate based on actual claim data submitted to the department for the previous 2 years.

(b) A physician or the physician's assignee may not hold an ownership interest in a licensed pharmaceutical repackaging entity and may not set or cause to be set a repackaged pharmaceutical average wholesale price.

(18) ~~(17)~~ PENALTIES.—A person who fails ~~Failure~~ to comply with this section violates the provisions ~~shall be considered a violation~~ of this chapter and is subject to penalties as provided for in s. 440.525.

Section 2. This act shall take effect July 1, 2013.