

STATEWIDE PROVIDER AND HEALTH PLAN CLAIM DISPUTE RESOLUTION PROGRAM

2018 Annual Report

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Statewide Provider and Health Plan Claim Dispute Resolution Program

Annual Report for Data Collected in 2018

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 1st 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 were not resolved by the provider and the managed care organization. The statute requires the Agency to contract with a resolution organization to timely review and consider claim disputes and 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 the rule necessary to implement the program (59A-12.030, Florida Administrative Code (F.A.C.)), 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 May 1, 2001.

MAXIMUS operates a toll-free hotline (1-866-763-6395, Option 2) 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 associated review costs. In cases where both parties prevail in part the review costs 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 (HMOs), prepaid health clinics (PHCs), exclusive provider organizations (EPOs) and prepaid health plans (PHPs). In 2002, the Legislature expanded the program to include other insurers offering major medical expense insurance policies and preferred provider organizations (PPOs). The revision 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 the program are further defined in Rule 59A-12.030, F.A.C., consistent with statutory provisions.

Eligible Claims

The following claim disputes can be submitted by physicians, hospitals, institutions, other licensed health care providers, HMOs, PHCs, EPOs, PHPs, major medical expense health insurance policies offered by a group or an individual health insurer, and PPOs.

- Claim disputes for services rendered after October 1, 2000 (the effective date of the initial legislation).
- Claim disputes related to payment amounts only (provider disputes payment amounts received, or HMO disputes payback amounts). Claim disputes related exclusively to late payment are not eligible.
- Hospitals and physicians are required to aggregate claims (for one or more patients for same insurer) 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

- Claims for less than the minimum amounts listed above for each type of service
- Claim disputes that are the basis for an action pending in State/Federal court
- Claim disputes that are subject to an internal binding managed care organization's resolution process for contracts entered into prior to October 1, 2000
- Claims solely related to late payment and/or late processing
- Interest payment disputes
- Medicare claim disputes that are part of a Medicare Managed Care internal grievance or that qualify for a Medicare reconsideration appeal
- Medicaid claim disputes that are part of a Medicaid Fair Hearing
- Claims related to health plans not regulated by the State of Florida
- Claims filed more than 12 months after a final determination by a health plan or provider

Claim Disputes

In 2018, 70 claim disputes were filed by hospitals, practitioners, institutions and other licensed health care providers for consideration. Six of the 70 claim disputes filed were accepted as eligible claims for review as indicated below:

Eligible Claims Accepted for Review

Case Number	Provider Name	Respondent	Disputed Amount	Case Outcome
FL18-000002	R.K. Healthcare	United Healthcare	\$621.50	Provider Withdrawal
FL18-000003	Psych Solutions, Inc.	Magellan	\$268,946.68	Health Plan Opted Out
FL18-000004	Behavior Services of Brevard	Cigna HealthCare of Florida	\$41,835.74	Final Order Amount Awarded \$41,835.74
FL18-000005	Pediatric Gastroenterology of Central Florida	Amerigroup	\$1,734.00	Health Plan Opted Out
FL18-000006	Premier Spine Center, Inc.	Cigna HealthCare of Florida	\$2,649.21	Dismissed (Self-Insured)
FL18-000008	Med-Trans Air Medical Transpor	Prestige Health Choice	\$2,043.82	Health Plan Opted Out

The remaining claim disputes that were filed were not accepted for the following reasons:

- 32 are currently under review for acceptance
- 16 were withdrawn as the health plan opted out
- 6 were withdrawn by the provider
- 10 were dismissed as they did not meet eligibility requirements.

The 70 claim disputes involved Aetna Health Plan, Amerigroup, AvMed, Blue Cross Blue Shield of Florida, Cigna HealthCare, Florida MHS, Inc. (Magellan), Florida True Health Inc. (Prestige), Humana, Molina HealthCare of Florida, Prestige Health MCD HMO, Sunshine State Health Plan, UniCare, UnitedHealthcare and Wellcare Health Plan.

The claim dispute amounts filed ranged from a low of \$199.00 to a high of \$1,101,790.45. Each claim dispute generally represents several aggregated claims.