The M.A.R.C.®, Inc.

Auto No Fault
and
Workers' Compensation

Beat Par for the Course and Maximize Your Reimbursement

Tonya R. Emerson, CPAT

Director, Patient Business Services

A Blue Chip Enterprise

- Auto No-Fault
  - Identify Auto No-Fault Accounts
  - State Mandated Coverage / Optional Coverage
  - PIP Fee Schedule
  - Proper Application of Deductible
  - ER Physician Reserve / Timely Filing
  - EMC Temporary PIP Injunction Upheld
  - Will Senate Consider SB 7152
  - PIP Demand

Identify Auto No-Fault Accounts

- Bicyclist or Pedestrian hit by car
- Motorcyclist hit/ran off road by a car
- Rental Car Coverage
- Finger/Hand caught in door or window
- Patient getting in or out of vehicle
- Patient working on vehicle - Car Jack Collapsed Car
- Steam Burn - Radiator Cap/Hose explodes
- Acid Burn - Battery Blows Up
- Driver is mugged while inserting key into car door
- Driver is shot while sitting in car
- Early Labor Claims Due to Accident

State Mandated / Optional Coverage

- State Mandated Coverage
  - PIP - $10,000.00
    - 80% Medical Expenses
    - 60% Disability Benefits
    - $5,000 Death Benefits – Reduced from $10K PIP
    - Optional PIP Deductible - $250, $500 or $1,000
    - $5,000 Reserve of PIP Benefits for ER or IP physician bills
  - PD - $10,000.00
- Optional Coverage
  - Extended PIP
  - Med-Pay
  - B/I Liability
  - U/M – Uninsured/Underinsured Motorist

PIP Fee Schedule

- An insurer MAY limit reimbursement to 80% of the following:
  - Ambulance transport & treatment – *200% of Medicare*
  - ER services and care by a hospital – *75% charges*
  - ER services and care provided in a facility licensed under chapter 395 rendered by a physician or dentist and related hospital inpatient services rendered by a physician or dentist – *U&C Charge*

PIP Fee Schedule – Cont.

- For hospital Inpatient services, other than emergency services and care, *200% of the Medicare Part A prospective payment applicable to the SPECIFIC hospital providing the care.*
- For hospital outpatient services, other than emergency services and care, *200% of the Medicare Part A APC for the specific hospital providing the outpatient services.*

PIP Fee Schedule – Cont.

- For all other medical services, supplies and care, 200% of the allowable amount under:
  - The participating fee schedule of Medicare Part B, except as provided below
  - Medicare Part B, for services, supplies and care provided by ASC or clinical Lab
  - The DME Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B for DME
  - Cannot be less then the 2007 Medicare FS

PIP Fee Schedule – Cont.

- **If such services, supplies or care is not reimbursable under Medicare Part B, *the insurer may pay 80% of the reimbursement amount under the WC Fee Schedule***
- **If such services are not reimbursable under the WC Fee Schedule *the insurer is not required to issue payment.***
- **If an insurer limits payment to the fee schedule the provider of service *may not bill or attempt to collect from the INSURED any amount in excess of such limits, except for the amounts that are NOT covered by the insured's PIP coverage due to the coinsurance amount or maximum policy limits.***

Proper Application of Deductible

- Deductibles
  - $250.00, $500.00 & $1,000.00
  - Applied towards 100% of Total Charges
  - Example:
    - TC - $6,500.00 x 75% = $4,875.00 - $1,000.00 =$3,875.00 x 80% = **$3,100.00** PIP Pmt / **$1,625.00** PIP Cont Adj.
    - TC - $6,500.00 - $1,000.00 = $5,500.00 x 75% =$4,125.00 x 80% = **$3,300.00 -** PIP Pmt / **$1,375.00** PIP Cont Adj. *Difference: Pmt -* ***$200.00*** *PIP Cont* ***-$250.00 = $450.00***

Proper Application of Deductible

- Example
  - TC - $1,200.00 x 75% = 900.00 x 80% = $720.00 (Amount applied towards deductible.) **$0.00** - PIP Pmt / **$300.00** - PIP Contractual
  - TC - $1,200.00 - $1,000.00 = $200.00 x 75% = $150.00 x 80% = **$120.00** - PIP Pmt / **$50.00** - PIP Contractual
    - *Difference:* – Pmt - $120.00 / PIP Cont Adj. $250.00 = $370.00

Proper Application of Deductible

- January 2013 Ruling - Case No.: 2011-SC-8737
  - Deductible must be applied to 100% of charges BEFORE any Fee Schedule reduction
  - Deductible must be satisfied by application of the bills submitted to the insurer by NON-protected providers, and UPON satisfaction of the deductible in such manner, THEN the protected provider is entitled to have its bill paid.
  - Protected Providers – ER and Inpatient charger by Physicians licensed under chapter 458 or 459 & Dentists licensed under chapter 466

ER Physician Reserve / Timely Filing

- **ER & Inpatient Physician Reserve**
  - Who provide emergency services and care, or who provide hospital inpatient care.
  - The amount required to be held in reserve may be used ONLY to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident.
  - After the 30 day period, any amount of the reserve for which the insurer has NOT received notice of a claim from a physician or dentist who provided emergency services and care or provided hospital inpatient care may then be used by the insurer to pay other claims.
- **Timely Filing**
  - Does not apply to hospital, ambulance or ER or Inpatient Physician
  - All other claims must be mailed within 35 days of treatment OR notification of auto insurance by the patient
  - Can send Initiation of Treatment letter within 35 days to toll billing for 75 days

EMC Temporary PIP Injunction Upheld

- 03/15/13 - **Order Granting Temporary Injunction** was signed by Leon County Judge Terry Lewis stating, "The Plaintiffs' motion is granted as to those sections of the law which *require a finding of* ***emergency medical condition as a prerequisite for payment of PIP benefits*** *OR* ***that prohibit payment of benefits for services provided by acupuncturists, chiropractors and massage therapists***. In all other respects, the motion is denied."
- 03/22/13 – Temporary Injunction Order Appealed
- 04/17/13 – Order Granting Motion to Vacate Automatic Stay
- 04/19/13 – Automatic Stay Appealed
- 06/17/13 – Temporary Injunction Upheld
  - Case No. **1D13-1355** – First District Court of Appeal
  - PIP Carriers can **NO longer deny OR reduce PIP claims for** lack of an **EMC certification**.

Will Senate Consider SB 7152

- Florida Senator David Simmons, R-Maitland: "Let's give PIP the slip" *<u>was met with silence from members</u>* of his committee when he asked if they wanted to debate the proposal (SB 7152) to scrap PIP.
  - (SB 7152) Proposes to end the state's no-fault law and replace it with $25,000.00 mandatory B/I with a $50,000.00 limit on per-accident medical care and damages.
    - The bill was written as an alternative to PIP once the new law was considered unconstitutional
    - Be on the lookout for discussion on replacing PIP during the next Legislative Session.
    - Reach out to your lobbyists and members of both the senate to make your voice heard in this regard.
    - Without PIP benefits hospitals will treat patients for free and patients will go without treatment if they do not have health insurance as most Doctors will treat first and get paid at time of settlement.

PIP Demand

- Written notice of Intent to Initiate Litigation due to PIP underpayment.
  - Notice must state it is a Demand Letter
  - Name of Insured and Claim Number
  - Name of Medical Provider
  - Itemized Statement
  - Patient Assignment of Benefits
  - Certified or Registered Mail RRR
  - Insurer has 35 days from date received to respond before provider can initiate litigation

Topics For Today

- Workers’ Compensation
  - Timely Filing / Timely Payment
  - Minimum Partial Payment & Denial EOB
  - 2013 Vs 2008 Coding Issues
    - Hospital Manual 2006
    - Healthcare Provider Manual 2008
  - Out of State Carriers / DOL & DOE Claims
  - Petition of Resolution

Timely Filing & Payment

- Timely Filing
  - Providers have 1 year from date of service for outpatient claims or date of discharge for inpatient Claims.
- Timely Payment
  - WC to pay claims within 45 days of receipt of bill
  - WC has 120 days to adjust, disallow or deny claim
  - Can impose 12% annual interest on late payments but you must request it; as they will not issue it.

Minimum Partial Pmt & Denial EOB

- WC carrier shall remit a minimum partial payment as follows:
  - IP – the applicable per diem rate for which hospital has an authorization and no dispute as to medical necessity.
  - OP- the applicable reimbursement for each itemized charge not denied, disallowed or disputed
- Denial EOB must state why the claim or charge was denied or disallowed
  - Cannot reduce for U&C as AHCA has determined a provider's billed charges are the U&C charges if they match the Provider's Charge Master.
  - Denied charges for incorrect coding should be re-billed and not written off as a WC contractual.

2013 Vs 2008 Coding Issues

- Coding Issues – WC Stuck in 2008
  - Hospital Manual – 2006
    - OP CPT Denials as, "Not a Valid Code" or "Not compatible with Revenue Code"
      - Re-bill with the 2008 CPT code instead of the 2013
  - Healthcare Provider Manual – 2008
    - CPT Denials as, "Not a Valid CPT Code"
    - WC has not updated their CPT files since 2008 and the new CPT code changes are not listed in the WC Manual and therefore WC will deny the entire claim or just the incorrect code line.
      - Appeal & Re-bill with the 2008 CPT code instead of the 2013, do not write off!!

SOUTHWEST FLORIDA BLUE CHIP COMMUNITY BUSINESS AWARD

MEDICAL A/R CONSULTANTS

Out of State Carriers / DOL & DOE Claims

- Out of State Carriers
  - Jurisdiction Rules
    - If out of state patient was injured in FL, they pay FL rates
    - If out of state patient MOVES to FL, they now pay FL rates.
- DOL & DOE Claims
  - Pay their own Federal Fee Schedule not State
  - Will only cover approved Diagnosis
  - Need to work with patient and case worker to get additional diagnosis approved.
    - Side affects of medication prescribed for covered injury

Petition of Resolution

- Petition of Resolution
  - Must be filed within 30 days from date EOB was received via certified mail return receipt requested
    - Can only file on first EOB and not on denial of appeal
  - Carrier has 10 days to respond & Failure to respond means they owe the bill.
    - If there is a deficiency you have 10 days to correct the petition and re-send to all involved parties.
  - Agency must respond to Petition within 60 days of receipt of all requested documents
  - If Petition is denied you have 21 days to file an ALJ Hearing to challenge the outcome.

Questions?

Tonya R. Emerson, CPAT
Director, Patient Business Services
The M.A.R.C.®, Inc.
tonya@themarc.com
239-277-0006
www.themarc.com