69L-7, F.A.C.: WORKERS’ COMPENSATION MEDICAL REIMBURSEMENT AND UTILIZATION REVIEW

69L-7.710 Florida Workers’ Compensation Medical Services Billing, Filing and Reporting Rule.

(1) Definitions

(a) “Accurately Complete” or “Accurately Completed” means the form submitted contains the information necessary to meet the requirements of Chapter 440, F.S., and this rule.

(b) “Adjust” or “Adjusted” means payment is made with modification to the information provided on the bill.

(c) “Ambulatory Surgical Center” is defined in subsection Section 395.002(3), F.S.

(d) “Average Wholesale Price” or “AWP” is as defined in paragraph 440.13(12)(c), F.S., for medications dispensed on or after July 1, 2013.

(e) “Billing” means the process by which a health care provider submits a medical claim form or medical bill to an insurer, claim service company/third party administrator or any entity acting on behalf of the insurer, to receive reimbursement for medical services, goods or supplies provided to an injured employee.

(f) “Catastrophic Event” means the occurrence of an event outside the control of a claim administrator or any entity acting on behalf of the insurer, such as an electronic data transmission failure due to a natural disaster or an act of terrorism (including but not limited to cyber terrorism), in which recovery time will prevent a claim administrator or any entity acting on behalf of the insurer from meeting the filing and reporting requirements of Chapter 440, F.S., and this rule. Programming errors, system malfunctions or electronic data interchange transmission failures that are not a direct result of a catastrophic event are not considered to be a catastrophic event as defined in this rule. See Rule 69L-7.750(4), F.A.C., paragraph (6)(d) for requirements to request approval of an alternative method and timeline for medical report filing with the Division due to a catastrophic event.

(g) “Charges” means the dollar amount billed.

(h) “Charge Master” means for hospitals a comprehensive listing of all the goods and services for which the facility maintains a separate charge, with the facility’s charge for each of the goods and services, regardless of payer type and means for ASCs a listing of the gross charge for each CPT procedure for which an ASC maintains a separate charge, with the ASC’s charge for each CPT procedure, regardless of payer type.

(i) “Claim Administrator” means any insurer, qualified servicing entity, third party administrator, claims-handling entity, self-serviced self-insured employer or fund, guarantee fund, or managing general agent, responsible for adjusting workers’ compensation claims.

(j) “Claim Administrator Code Number” means the number the Division assigns to an insurer, qualified servicing entity, third party administrator, claims-handling entity, self-serviced self-insured employer or fund, guarantee fund, or managing general agent, responsible for adjusting workers’ compensation claims.

(k) “Claim Administrator, Claims-Handling Entity File Number” means the number assigned to the claim file by the claim insurer or service company/third party administrator for purposes of internal tracking.

(l) “Current Dental Terminology” (CDT) means the American Dental Association’s reference document containing descriptive terms to identify codes for billing and reporting dental procedures, as incorporated by reference in 69L-8.074.

(m) “Current Procedural Terminology” (CPT) means the American Medical Association’s reference document (HCPCS Level I) containing descriptive terms to identify codes for billing and reporting medical procedures and services, as incorporated by reference in Rule 69L-8.074, F.A.C.

(n) “Date Insurer Paid Bill” and “Date Insurer Paid, Adjusted, Disallowed or Denied” means the date the claim insurer, service company/third party administrator-or any entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. If payment is disallowed or denied, “Date Insurer Paid
**Bill** and “Date Insurer Paid, Adjusted, Disallowed or Denied” means the date the claimant, service company/third party administrator or any entity acting on behalf of the insurer mails, transfers or electronically transmits the appropriate notice of disallowance or denial to the health care provider or the health care provider representative. See Rule 69L-7.750(8)(5)(l) for the requirement to accurately report the “Date Insurer Paid Bill date insurer paid”.

(o) “Date Insurer Received Bill” means the date that a Form DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or the electronic form equivalent is in the possession of the claimant, service company/third party administrator or any entity acting on behalf of the insurer. See Rule 69L-7.750(8), F.A.C., paragraph (5)(l) for the requirement to accurately report the “Date Insurer Received Bill date insurer received”. If a medical bill meets any of the criteria in Rule 69L-7.740(12)(b), F.A.C., paragraph (5)(l) of this rule and possession of the form is relinquished by the claim administrator, insurer, service company/TPA or any entity acting on behalf of the insurer by returning the medical bill to the provider with a written explanation for the insurer’s reason for return, then “Date Insurer Received Bill date insurer received” shall not apply to the medical bill as submitted.

(p) “Days” means calendar days unless otherwise noted.

(qm) “Deny” or “Denied” means payment is not made because the service rendered is for treatment of a non-compensable injury or illness.

(ra) “Department” means Department of Financial Services (DFS) as defined in subsection 440.02(12), F.S.

(se) “Disallow” or “Disallowed” means payment for a compensable injury or illness is not made because the service rendered has not been substantiated for reasons of medical necessity, insufficient documentation, lack of authorization or billing error.

(tp) “Division” means the Division of Workers’ Compensation (DWC) as defined in subsection 440.02(14), F.S.

(uq) “Electronic Filing” means the computer exchange of medical data from a sender to the Division in the standardized format defined in the Florida Medical EDI Implementation Guide (MEIG).

(yr) “Electronic Form Equivalent” means the record format, provided in the Florida Medical EDI Implementation Guide (MEIG) to be used when a sender electronically transmits required data to the Division. Electronic form equivalents do not include transmission by facsimile, data file(s) attached to electronic mail, or computer-generated paper-forms.

(w) “Electronically Filed with the Division” means the date an electronic filing has been received by the Division and has successfully passed structural and data-quality edits.

(xt) “Entity” means any party involved in the processing, adjudication or payment of medical bills on behalf of the insurer.

(yu) “Explanation of Bill Review” (EOBR) means the document used to provide notice of payment or notice of adjustment, disallowance or denial by a claimant by an insurer, service company/third party administrator or any entity acting on behalf of an insurer to a health care provider containing code(s) and code descriptor(s), in conformance with Rule 69L-7.750(11)(b)3., F.A.C. subsection (5) of this rule.

(zw) “Explanation of Bill Review Code” (EOBR Code) means a code listed in Rule 69L-7.740(11)(b)3., F.A.C. subparagraph (5)(o)2. of this rule that describes the basis for the reimbursement decision of a claim administrator, insurer, service company/TPA or any entity acting on behalf of the insurer.

(aa) “Florida Medical EDI Implementation Guide (MEIG)” is the Florida Division of Workers’ Compensation’s reference document containing the specific electronic formats, data elements, and requirements required for insurer reporting of medical data to the Division, as incorporated by reference in Rule 69L-8.074, F.A.C.

(bb) “Healthcare Common Procedure Coding System National Level II Codes (HCPCS)” (HCPCS) means the Centers for Medicare and Medicaid Services’ (CMS) reference document listing descriptive codes for billing and reporting professional services, procedures, and supplies provided by health care providers, as incorporated by reference in Rule 69L-8.074, F.A.C.

(cc) “Health Care Provider” is defined in subsection 440.13(1)(gh), F.S.

(dd) “Home Health Agency” is defined in subsection 400.462(12), F.S.
“Home Medical Equipment Provider” (sometimes referred to as durable medical equipment (DME) provider) is defined in subsection 400.925(7), F.S.

“Hospital” is defined in subsection 395.002(12), F.S.


“Insurer” is defined in section 440.02, (38), F.S.

“Insurer Code Number” means the number the Division assigns to each individual insurer, self-insured employer, or self-insured fund, or guaranty fund financially responsible for the claim.

“Itemized Statement” means a detailed listing of goods, services and supplies provided to an injured employee, including the quantity and charges for each good, service or supply.

“Medical Bill” means the document or electronic form equivalent submitted by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer for reimbursement for services or supplies (e.g. DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, DFS-F5-DWC-90 or the provider’s usual invoice or business letterhead) as appropriate pursuant to Rule 69L-7.730(2), F.A.C. paragraph (4)(b) of this rule.

“Medically Necessarily” or “Medical Necessity” is defined in paragraph 440.13(1)(k), F.S.

“NDC Number” means the eleven-digit National Drug Code (NDC) number, assigned under Section 510 of the Federal Food, Drug, and Cosmetic Act, which identifies the drug product labeler/vendor, product, and trade package size. As used in this Chapter, when referring to dispensed drugs, “Original NDC Number” shall mean the NDC Number assigned by the original manufacturer of the underlying dispensed drug; and, “Repackaged NDC Number” shall mean the NDC Number assigned by the repackager/relabeler of the underlying dispensed drug. The NDC number is an eleven-digit number that is expressed in the universal 5-4-2 format and included on all applicable reports with each of the three segments separated by a dash (-).

“Nursing Home Facility” is defined in subsection 400.021(12), F.S.

“Pay” or “Paid” means payment is made applying the applicable reimbursement formula to the medical bill as submitted.

“Physician” is defined in paragraph 440.13(1)(p), F.S.

“Primary Physician” means the treating physician responsible for the oversight of medical care, treatment and attendance rendered to an injured employee, to include recommendation for appropriate consultations or referrals.

“Recognized Practitioner” means a non-physician health care provider licensed by the Department of Health who works under the protocol of a physician or who, upon referral from a physician, can render direct billable services that are within the scope of their license, independent of the supervision of a physician.

“Report” means any form related to medical services rendered, in relation to a workers’ compensation injury, that is required to be filed with the Division under this rule.

“Service Company/Third Party Administrator (TPA)” means an entity that has contracted with an insurer for the purpose of providing services necessary to adjust workers’ compensation claims on the insurer’s behalf.

“Service Company/Third Party Administrator (TPA) Code Number” means the number the Division assigns to a service company, adjusting company, managing general agent or third party administrator.

“Submitter” means an insurer, service company/TPA, entity or any other party acting as an agent on behalf of an insurer, service company/TPA or any entity to fulfill any insurer responsibility to electronically transmit required medical data to the Division.

1 The following forms, including form completion instructions, are incorporated for use with rules adopted under this Chapter.

(a) Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 02/12/08/05); Form DFS-F5-DWC-9-B (Completion Instructions for Form DFS-F5-DWC-9: comprised of two sets of completion instructions; one for use by health care providers, Rev. 11/1/2013; and, one for use by ambulatory surgical centers, work hardening and pain management programs, Rev. 11/1/2013).

(b) Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Equipment & Supplies Form), Rev. 11/1/13.

(c) Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2012/2006); Form DFS-F5-DWC-11-B (Completion Instructions for Form DFS-F5-DWC-11), Rev. 11/1/2013.

(d) Form DFS-F5-DWC-25 (Florida Workers’ Compensation Uniform Medical Treatment/Status Reporting Form), Rev. 1/31/08.

(e) Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006); Form DFS-F5-DWC-90-B (Completion Instructions for Form DFS-F5-DWC-90 (Rev. 11/1/13/09), Rev. 11/1/13/09); Form DFS-F5-DWC-90-C (Completion Instructions for Form DFS-F5-DWC-90 (for use by Ambulatory Surgical Centers), Rev. 11/1/13/09); Form DFS-F5-DWC-90-D (Completion Instructions for Form DFS-F5-DWC-90 (for use by Home Health Agencies), Rev. 11/1/13/09); DFS-F5-DWC-90-E (Completion Instructions for Form DFS-F5-DWC-90 (for use by Nursing Home Facilities), Rev. 11/1/13/09).

2 Obtaining Copies of Forms and Instructions.

(a) A copy of the Form DFS-F5-DWC-9 can be obtained from the AMA web site: https://commerce.ama-assn.org/store/. Completion instructions for the form can be obtained from the Department of Financial Services/Division of Workers’ Compensation (DFS/DWC) web site:

http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm

(b) A copy of the Form DFS-F5-DWC-10 and completion instructions for the form can be obtained from the DFS/DWC web site:

http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm, the DFS/DWC web site:


(c) A copy of the Form DFS-F5-DWC-11 can be obtained from the American Dental Association web site:

http://www.ada.org/, Completion instructions for the form can be obtained from the DFS/DWC web site:

http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm


(d) A copy of the Form DFS-F5-DWC-25 and completion instructions can be obtained from the DFS/DWC web site:


(e) A copy of the instructions for completion of Form DFS-F5-DWC-90 (Rev. 2006), Form DFS-F5-DWC-90-B (for hospitals) (Rev. 11/1/13/09), Form DFS-F5-DWC-90-C (for ASCs) (Rev. 11/1/13/09), Form DFS-F5-DWC-90-D (for Home Health Agencies), Form DFS-F5-DWC-90-E (for Nursing Home Facilities), Rev. 11/1/13/09, can be obtained from the DFS/DWC web site:


3 Alternate Billing Form DFS-F5-DWC-10.
In lieu of submitting a Form DFS-F5-DWC-10, when billing for drugs or medical supplies, alternate billing forms are acceptable if:

(a) An insurer has approved the alternate billing form(s) prior to submission by a health care provider, and

(b) The form provides all information required to be submitted to the Division, pursuant to the applicable Florida Medical EDI Implementation Guide (MEIG), on the Form DFS-F5-DWC-10. Form DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be submitted as an alternate form for the DFS-F5-DWC-10.

69L-8, F.A.C. Selected(3) Materials Incorporated(4) by Reference
69L-8.074, F.A.C. Materials for use throughout Rule Chapter 69L-7

(1) The Workers’ Compensation Medical Reimbursement and Utilization Review, Chapter Rule 69L-7, adopts all reference materials that following publications are incorporated by reference herein. The incorporated reference materials are as follows:


(c) The Current Dental Terminology, CDT-2013, Copyright 2012, American Dental Association, as adopted in Rule 69L-7.020, F.A.C.


(g) The Minnesota Department of Labor and Industry Disability Schedule, as adopted in Rule 69L-7.604, F.A.C.

(h) The Florida Impairment Rating Guide, as adopted in Rule 69L-7.604, F.A.C.

(i) The 1996 Florida Uniform Permanent Impairment Rating Schedule, as adopted in Rule 69L-7.604, F.A.C.


(n) The Florida Workers’ Compensation Reimbursement Manual for Hospitals, Rule 69L-7.730501, F.A.C.

(o) The Florida Workers’ Compensation Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.700, F.A.C.


(1) Health Care Provider Responsibilities.

(1a) Bill Submission/Filing and Reporting Requirements.

(a) All health care providers are responsible for meeting their obligations, under this rule, regardless of any business arrangement with any entity under which claims are prepared, processed or submitted to the insurer.
Each health care provider is responsible for submitting any form completion information and supporting documentation requested by the insurer that is in addition to the requirements of this rule and the applicable reimbursement manual, when it is requested, in writing, by the insurer at the time of authorization or upon receipt of notification of emergency care.

Each health care provider shall resubmit a medical claim form or medical bill with insurer requested documentation when the EOB provides an explanation for the disallowed service based on the provider’s failure to submit requested documentation with the medical bill.

Insurers and health care providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of the injured employee’s medical treatment/status. No other reporting forms may be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

The Form DFS-F5-DWC-25 does not replace physician notes, medical records or Division-required medical reports.

All information submitted on physician notes, medical records or Division-required medical reports shall be consistent with information documented on the Form DFS-F5-DWC-25.

The DFS-F5-DWC-25, submitted to address the physical limitation(s), permanent impairment rating or maximum medical improvement date, shall be signed by the physician performing the physical examination upon which the physical limitation(s), permanent impairment or maximum medical improvement date is based.

All medical claim form(s) or medical bill(s) related to authorized services shall be coded by the health care provider at the highest level of specificity and submitted to the claim administrator, insurer, service company/TPA or any entity acting on behalf of the insurer, as a requirement for billing.

Medical claim form(s) or medical bill(s) may be electronically filed or submitted via facsimile by a health care provider to the claim administrator, insurer, service company/TPA or any entity acting on behalf of the insurer, provided the insurer agrees.

When requested by the claim administrator, insurer, service company/TPA or any entity acting on behalf of the insurer, a health care provider shall send documentation that supports the medical necessity of the specific services rendered and any other required documentation pursuant to Rule 69L-7.730(2), F.A.C., paragraph (4)(b) of this rule and the applicable reimbursement manual.

Each health care provider is responsible for correcting and resubmitting any billing forms returned by a claim administrator, insurer, service company/TPA or any entity acting on behalf of the insurer pursuant to Rule 69L-7.740(10)(e), F.A.C., paragraph (5)(j) of this rule.

Each hospital and ambulatory surgical center shall maintain its charge master and shall produce relevant portions when requested for the purpose of verifying its usual charges pursuant to Section 440.13(12)(d), F.S.

A health care provider shall bill multiple services, rendered on the same date of service, on a contiguous bill; provided however, nothing herein shall prevent a physician from selling, assigning or otherwise factoring a claim for the provision of pharmacy related services to a third party.

Special Billing Requirements.

When anesthesia services are billed on a Form DFS-F5-DWC-9, completion of the form shall include the CPT® code and the “P” code (physical status modifier), which correspond with the procedure performed, in Field 24D. Anesthesia health care providers shall enter the date of service and the 5-digit qualifying circumstance code, which correspond with the procedure performed, in Field 24D on the next line, if applicable.

When a Certified Registered Nurse Anesthetist (CRNA) provides anesthesia services, the CRNA shall bill on a Form DFS-F5-DWC-9 for the services rendered and enter his/her Florida Department of Health ARNP license number in Field 33b, regardless of the employment arrangement under which the services were rendered, or the party submitting the bill.

Recognized practitioners, except physician assistants, advanced registered nurse practitioners, certified registered nurse anesthetists, who are salaried employees of an authorized treating physician and, who render direct billable services for which reimbursement is sought from the claim administrator, insurer, service company/TPA or any entity acting on behalf of the claim administrator, insurer, service company/TPA.
administrator insurer, service company/TPA, shall report and bill for such services on a Form DFS-F5-DWC-9 by entering the employing physician’s Florida Department of Health license number in Field 33b on the Form DFS-F5-DWC-9.

(d)4. For hospital billing, the following special requirements apply:

1a. Inpatient billing – Hospitals shall, in addition to filing a Form DFS-F5-DWC-90:

aI. Attach an itemized statement with charges based on the facility’s Charge Master; and

bI. Submit all specifically requested and additional documentation requested at the time of authorization; and

cI. Bill professional services provided by a physician, physician assistant, advanced registered nurse practitioner, or registered nurse first assistant on the Form DFS-F5-DWC-9, regardless of employment arrangement;

2b. Outpatient billing – Hospitals shall in addition to filing a Form DFS-F5-DWC-90:

aI. Enter the CPT®, HCPCS or workers’ compensation unique code and the applicable CPT® or HCPCS modifier code in Form Locator 44 on the Form DFS-F5-DWC-90, when required pursuant to the UB-04 Manual; and

bI. Make written entry “scheduled” or “non-scheduled” in Form Locator 80 of Form DFS-F5-DWC-90 revision 2006 – ‘Remarks’ on the DFS-F5-DWC-90, when billing outpatient surgery or outpatient surgical services; and

cI. Attach an itemized statement with charges based on the facility’s Charge Master; and

dI. Submit all applicable documentation required pursuant to Rule 69L-7.501, F.A.C.;

eI. Bill professional services provided by a physician or recognized practitioner on the Form DFS-F5-DWC-9, regardless of employment arrangement;

(e)5. A certified, licensed physician assistant, and registered nurse first assistant who provides services as a surgical assistant, in lieu of a second physician, shall bill on a Form DFS-F5-DWC-9 entering the CPT® code(s) plus modifier(s), which represent the service(s) rendered, in Field 24D, and shall enter his/her Florida Department of Health license number in Field 33b.

(f)6. Ambulatory Surgical Centers (ASCs) shall bill as follows:

a. For dates of service up to and including 07/07/2010, ASCs shall bill on Form DFS-F5-DWC-9 using the American Medical Association’s CPT® procedure codes, or using the workers’ compensation unique procedure code 99070 with required modifiers and shall bill charges based on the ASC’s Charge Master except when billing for procedure code 99070.

b. For dates of service on or after 07/08/2010, Ambulatory Surgical Centers shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS or workers’ compensation unique code and the applicable CPT® or HCPCS modifier code in Form Locator 44 for each service rendered. ASCs shall bill charges based on the ASC’s Charge Master except when billing for surgical implants, associated disposable instrumentation and applicable shipping and handling. ASCs shall use Revenue Center Code 0278 and workers’ compensation unique code(s) with required modifier(s) pursuant to Rule 69L-7.100, F.A.C., when billing for surgical implants, associated disposable instrumentation, and applicable shipping and handling pursuant to Rule 69L-7.100, F.A.C. ASC medical bills shall be accompanied by all applicable documentation or certification required pursuant to Rule 69L-7.100, F.A.C.

(g)7. Home Health Agencies (HHAs) shall bill on Form DFS-F5-DWC-90.

a. For dates of service up to and including 07/07/2010, HHAs shall bill on letterhead or invoice.

b. For dates of service on or after 07/08/2010, HHAs shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS or workers’ compensation unique codes and the applicable CPT® or HCPCS modifier code in Form Locator 44 for each service rendered.

(h)8. Nursing Home Facilities shall bill on Form DFS-F5-DWC-90.

a. For dates of service up to and including 07/07/2010, Nursing Home Facilities shall bill on letterhead or invoice.
b. For dates of service on or after 07/08/2010, Nursing Home Facilities shall bill on Form DFS-F5-DWC-90 and shall enter the CPT®, HCPCS or workers’ compensation unique code and the applicable CPT® or HCPCS modifier code in Form Locator 44 for each service rendered.

(i) Federal Facilities shall bill on their usual form.

(i) Out-of-State health care providers shall bill on the applicable medical bill form pursuant to Rule 69L-7.730(3), F.A.C paragraph (4)(c) of this rule.

(k) Dental Services.

a. Dentists shall bill for services on Form DFS-F5-DWC-11.

b. Oral surgeons shall bill for oral and maxillofacial surgical services on a Form DFS-F5-DWC-9. Non-surgical dental services shall be billed on Form DFS-F5-DWC-11.

3e. When dispensing medications, dentists and oral surgeons shall submit charges on the forms specified in Rule 69L-7.730(2)(k)(1) paragraphs 11.a. and 2), F.A.C paragraphs above.

(i) Pharmaceuticals, Durable Medical Equipment and Home Medical Equipment or Supplies.

1a. When dispensing commercially available medicinal drugs commonly known as legend or prescription drugs:

aI. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the 11 digit Original NDC Number in the universal 5-4-2 format in Field 9a. When the dispensed drug is a repackaged/relabelled drug, the provider shall, in addition to the above, enter the Repackaged NDC Number in Field 9b of Form DFS-F5-DWC-10, with each segment separated by a dash (-).

bII. Physicians, physician assistants, or ARNPs, and any other recognized practitioner licensed to dispense medications pursuant to section 465.0276, F.S., shall bill on Form DFS-F5-DWC-9 and shall enter the dispensed drug’s 11 digit NDC number in the shaded portion of Field 24D. When the dispensed drug is a repackaged/relabelled drug, the provider shall enter the Original NDC Number preceded by the alpha-numeric qualifier (N4) followed by the Repackaged NDC Number preceded by the alpha-numeric qualifier (N4) NDC number, in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). The workers’ compensation unique code DSPNS shall be entered in Field 24D for each line item for which an NDC number(s) is listed in the shaded portion above Field 24D. Office visit must be billed on the DWC-9.

cIII. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

b. When dispensing medicinal drugs which are compounded and the prescribed formulation is not commercially available:

aI. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the workers’ compensation unique code COMPD in Field 9a.

bII. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the workers’ compensation unique code COMPD in Field 24D.

cIII. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

3e. When dispensing over-the-counter drug products:

aI. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the 11 digit NDC number, in the universal 5-4-2 format in Field 9a, with each segment separated by a dash (-).

bII. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the 11 digit NDC number, preceded by the alpha-numeric qualifier (N4), in the shaded portion above universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). Medication dispensed by a physician or recognized practitioner during an office visit shall be billed on the DWC-9.

cIII. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

4d. When administering or dispensing injectable drugs:
aI. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the 11 digit NDC number in the universal 5-4-2 format, in form Field 9a, with each segment separated by a dash (−).

bII. Physicians, physician assistants or ARNPs shall bill on a Form DFS-F5-DWC-9 and enter the appropriate HCPCS “J” code in form Field 24D. When an appropriate HCPCS “J” code is not available for the injectable drug, enter the 11 digit NDC number, preceded by the alpha-numeric qualifier (N4), in the shaded portion above universal 5-4-2 format in form Field 24D, with each segment separated by a dash (−).

cIII. Hospitals shall bill on Form DFS-F5-DWC-90 using the appropriate revenue codes.

d. When dispensing durable medical equipment (DME):

aI. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10 (form revision 3/1/2009).

bII. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply.

cIII. Hospitals shall bill on Form DFS-F5-DWC-90 using the applicable revenue codes.

IV. Home Medical Equipment Providers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in form Field 21 on form revision 3/1/2009.

e. When dispensing medical supplies which are not incidental to a service or procedure:

I. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10 (form revision 3/1/2009).

II. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply.

c. Hospitals shall bill on Form DFS-F5-DWC-90 using the applicable revenue codes.

d. Home Medical Equipment Providers shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in form Field 21 on Form DFS-F5-DWC-10.

6. When dispensing medical supplies which are not incidental to a service or procedure:

a. Pharmacists shall bill on Form DFS-F5-DWC-10 and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10.

bII. Physicians and recognized practitioners shall bill on Form DFS-F5-DWC-9, shall enter the applicable HCPCS code in Field 24D and attach documentation indicating the actual cost of the supply.

c. Hospitals shall bill on Form DFS-F5-DWC-90 under the applicable revenue codes.

dIV. Home Medical Equipment Providers shall bill on Form DFS-F5-DWC-10 for DME supplies prescribed by a physician or recognized practitioner, and shall enter the applicable HCPCS code in Field 21 on Form DFS-F5-DWC-10 (form revision 3/1/2009).

7g. Pharmacists who provide Medication Therapy Management Services shall bill for these services on Form DFS-F5-DWC-9 by entering the appropriate CPT® code(s) 99605, 99606 or 99607 that represent the service(s) rendered in form Field 24D, shall enter their Florida Department of Health license number in Field 33b and shall submit a copy of the physician’s written prescription with the medical bill.

8b. Pharmacists and medical suppliers may only bill on an alternate to Form DFS-F5-DWC-10 when an insurer has pre-approved use of the alternate form. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be approved for use as the alternate form.

(m)13. Physicians billing for a failed appointment for a scheduled independent medical examination (when the injured employee does not report to the physician office as scheduled) shall bill worker’s compensation unique code 99456-CN on the DFS-F5-DWC-9.

(n)44. Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) shall accurately complete the Form DFS-F5-DWC-9 and submit the form to the insurer.
Parties that are not physicians or recognized practitioners but are authorized by an insurer to render services reimbursable under workers’ compensation shall bill on their invoice or letterhead. These parties shall not bill using Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90 as an invoice.

Only a physician as defined in paragraph 440.13(1)(p), F.S., can bill workers’ compensation unique codes 99455, 99456, 99457 when reporting services to address medical maximum improvement and permanent impairment.

Bill Completion.

Bills shall be legibly and accurately completed by all health care providers, regardless of location or reimbursement methodology, as set forth in this subpart and in Rule 69L-7.730(2), F.A.C section and paragraph (4)(b) of this rule.

Billing elements required by the Division to be completed by a health care provider are identified in Form DFS-F5-DWC-9-B (completion instructions Rev. 11/1/2013) available at the following websites:

- http://www.myfloridacfo.com/WC/pdf/DWC-9instrHCP_3-1
- http://www.myfloridacfo.com/WebView/Browser/pdf/DWC-9instrASC_1-1-07.pdf when submitted by Ambulatory Surgical Centers for dates of service up to and including 03/21/10;

Billing elements required by the Division to be completed for Pharmaceutical or Medical Supplier Billing are identified in Form DFS-F5-DWC-10 (completion instructions Rev.11/1/2013) available at website:


Billing elements required by the Division to be completed for Dental Billing are identified in Form DFS-F5-DWC-11-B (completion instructions Rev.11/1/2013) available at website: http://www.myfloridacfo.com/Division/WC/provider/DWC-11instr_1-1-07.pdf

Billing elements required by the Division to be completed for Form DFS-F5-DWC-90 are identified in the UB-04 Manual, and as follows;

1a. For Hospital billing, Form DFS-F5-DWC-90-B (UB-04) – B Completion Instructions, Rev. 11/1/2013 and Rule 69L-7.730(2)(d).subparagraph (4)(b)4. of this rule.

2b. For Ambulatory Surgical Center billing, Form DFS-F5-DWC-90-C (UB-04) – C Completion Instructions, Rev. 11/1/New 1/2013/2009 and Rule 69L-7.730(2)(f).subparagraph (4)(b)6. of this rule.

3e. For Home Health Agency billing, Form DFS-F5-DWC-90-D (UB-04) – D Completion Instructions, Rev. 11/1/New 1/2013/2009 and Rule 69L-7.730(2)(g).subparagraph (4)(b)7. of this rule.

4d. For Nursing Home Facility billing, Form DFS-F5-DWC-90-E (UB-04) – E Completion Instructions, Rev. 11/1/New 1/2013/2009 and Rule 69L-7.730(2)(h).subparagraph (4)(b)8. of this rule.

A health care provider shall submit additional data elements or supporting documentation that are required by the insurer that have been requested in writing pursuant to Rule 69L-7.740(2), F.A.C subparagraph (5)(b) of this rule.

A health care provider may bill consistent with the requirements of ICD-10 beginning on the implementation date specified for use of ICD-10 in section 62.1002 of Title 45 of the Code of Federal Regulations. Under no circumstance may a health care provider utilize both ICD-9 and ICD-10 coding on the same bill.

69L-7.740 Insurer Authorization and Medical Bill Review Responsibilities.
(5) Insurer Responsibilities.

(a) An insurer is responsible for meeting its obligations under this rule regardless of any business arrangements with any claim administrator/service company/TPA, submitter or any entity acting on behalf of an insurer under which medical bills are paid, adjusted and paid, disallowed, denied, or otherwise processed or submitted to the Division.

(b) At the time of authorization for medical service(s) or upon receipt of notification of emergency care, an insurer shall notify each health care provider, in writing, of data elements or supporting documentation that are necessary for reimbursement determinations that are in addition to the requirements of this rule and the applicable reimbursement manual.

(b)1. This subpart subparagraph applies to dates of injury occurring on or after October 1, 2003. At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall issue a written or electronic notice to each health care provider stating whether the insurer will, when paying reimbursement for the medical service(s) for a compensable injury, apportion out the percentage of need for the care attributable to a pre-existing condition pursuant to subsection Section 440.15(5), F.S. If the insurer decides to apportion out the percentage of need for the care attributable to the pre-existing condition after authorization, the insurer shall issue a written or electronic notice to each health care provider stating that it will apply such apportionment, pursuant to subsection Section 440.15(5), F.S., to the reimbursement for the authorized medical service(s). Compliance with this subpart subparagraph is independent of and does not satisfy the notification requirement pursuant to Rule 69L-3.017, F.A.C.

(c) At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall inform out-of-state health care providers of the specific reporting, billing and submission requirements contained in Rule 69L-7.730, F.A.C, subsection (4) (Health Care Provider Responsibilities) of this rule and provide in-state and out-of-state health care providers the specific address for submitting a reimbursement request.

(d) Insurers, service company/TPAs or entities acting on behalf of insurers and health care providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of an injured employee’s medical treatment/status. No other reporting forms may be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

(e) Required data elements on each electronic form equivalent of Form DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90, for both medical only and lost-time cases, shall be filed with the Division within 45-calendar days of when the medical bill is paid, adjusted, disallowed or denied by the insurer, claim administrator/service company/TPA or any entity acting on behalf of the insurer. The 45-calendar day filing requirement includes initial submission and correction and re-submission of all errors identified in the “Medical Bill Acknowledgement Processing Report”, as defined in the date-appropriate Florida Medical EDI Implementation Guide (MEIG).

(f) An insurer shall be responsible for accurately completing required data filed with the Division, pursuant to the date-appropriate Florida Medical EDI Implementation Guide (MEIG) and Rule 69L-7.750, F.A.C paragraphs (4)(e)2.5. of this rule. Additionally, an insurer or entity acting on behalf of an insurer shall be responsible for correcting previously accepted data that is deemed inaccurate by the Division through monitoring, auditing, investigation or analysis, and resubmitting the corrected and accurate data in accordance with the requirements set forth in the Florida Medical EDI Implementation Guide (MEIG) and Rule 69L-7.750(5), F.A.C paragraph (6)(e) of this rule.

(g) When an injured employee does not have a Social Security Number or a previously division-assigned Division-Assigned Number, the claim administrator or entity acting on behalf of the insurer shall contact the Division via email at DWCAssignedNumber@myfloridacfo.com information provided on the following web site: http://www.myfloridacfo.com/WC/organization/edc.html (under Records Management) to obtain a Division-Assigned Number assigned number prior to submitting the medical report to the Division.

(h) An insurer, claim administrator/service company/TPA or any entity acting on behalf of an insurer shall report to the Division the procedure code(s), number of line-items billed, diagnosis code(s), modifier code(s), NDC number(s) and amount(s) charged, as billed by the health care provider when reporting these data to the Division. However, the insurer, claim
or any entity acting on behalf of an insurer may correct the procedure code(s) or modifier code(s) or NDC number(s) to effect payment and shall report both the provider billed code(s) and insurer adjusted code(s) pursuant to the date-appropriate MEIG. The insurer, claim administrator or any entity acting on behalf of an insurer shall utilize the EOBR code “80” to notify the health care provider concerning any such billing errors and shall transmit EOBR code “80”, in instances when the carrier corrects the provider coding, when reporting to the Division.

(9) An insurer, claim administrator or any entity acting on behalf of the insurer shall manually or electronically date stamp accurately completed Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or the electronic form equivalent on the “Date Insurer Received Bill” as defined in Rule 69L-7.710 of this rule.

(10) When utilizing the option(s) available under Rule 69L-7.750(8)(a), F.A.C., the insurer shall document the following:
(a) The option(s) selected,
(b) The specific effective date for each option selected,
(c) The specific role of each “entity” acting on the insurers behalf in the option selected.

The insurer shall make this written documentation available to the Division for audit purposes pursuant to section 440.525, F.S. They shall maintain written documentation from the “entity” acknowledging its responsibilities concerning “Date Insurer Received Bill” and “Date Insurer Paid Bill” for each option when the insurer selects options 2, 3, or 4. from Rule 69L-7.750(8)(a), F.A.C., and shall also maintain written documentation identifying the applicability of the options selected in sufficient detail to allow verification of the coding of each medical bill under Rule 69L-7.750(8)(c), F.A.C.

(11) An insurer, claim administrator or any entity acting on behalf of the insurer shall comply as indicated below to ensure the timely and correct reimbursement of properly completed medical bills:
(a) When adjudicating practitioner-dispensed medication bills, an insurer, claim administrator or any entity acting on behalf of an insurer shall use Medi-Span Master Drug Database to determine whether or not the dispensed medication is repackaged.
(b) When a medical bill is submitted for reimbursement by a health care provider, the insurer, claim administrator or any entity acting on behalf of the insurer shall review the medical bill to determine if any of the criteria in Rule 69L-7.740(11)(e), F.A.C., subparagraph (5)(j)5. of this rule are present.
(c) If a medical bill is deficient according to the criteria listed in Rule 69L-7.740(11)(e), F.A.C., and the applicable form completion instructions incorporated by reference in Rule 69L-7.720, F.A.C., subparagraph (5)(j)5. of this rule, the insurer, claim administrator or any entity acting on behalf of the insurer shall either:
1a. Secure and/or correct the information on the medical bill and proceed to make a reimbursement decision to pay, adjust, disallow or deny billed charges within 45 calendar days from the “Date Insurer Received Bill” date insurer received; or
2b. Return the medical bill to the provider within twenty-one (21) days of the “Date Insurer Received Bill” with a written statement identifying the deficiency criteria under which the medical bill is being returned. The written statement sent to the provider with the returned medical bill shall bear the following statement CAPITALIZED and in BOLD print: “A HEALTH CARE PROVIDER MAY NOT BILL THE INJURED EMPLOYEE FOR SERVICES RENDERED FOR A COMPENSABLE WORK- RELATED INJURY”.
(d) If the insurer returns a medical bill to the provider pursuant to Rule 69L-7.740(11)(e), F.A.C., subparagraph (5)(j)5. of this rule, the written statement, which shall accompany the returned bill shall include all deficiency criteria upon which the return of the medical bill are based.
(e) If the deficiency criteria upon which the return of the medical bill is based includes any of the deficiency criteria in Rule 69L-7.740(11)(e)4-7, F.A.C., and the applicable form completion instructions subparagraphs (5)(j)5.d.-g. of this rule, the written statement shall identify the information that is illegible, incorrect, or omitted.
(f) An insurer may return a medical bill to a provider without issuance of an EOBR only on the basis of the deficiency criteria set forth in Rule 69L-7.740(11)(e), F.A.C., and the applicable form completion instructions subparagraph (5)(j)5. of this rule.

(g) The deficiency criteria upon which a medical bill is to be reviewed by the insurer, claim administrator, service company/TPA or entity acting on behalf of the insurer for return to the provider pursuant to this sub-part paragraph (5)(j) of Rule 69L-7.740(11), F.A.C., paragraph (5)(j) of this rule are:

1. Services are billed on an incorrect medical billing form; or
2. The medical bill has been submitted to the incorrect insurer; or
3. The medical bill has been submitted to the incorrect claim administrator, service company/TPA or entity acting on behalf of the insurer; or
4. Claimant identification information required by this rule and the applicable form completion instructions is illegible on the medical bill; or
5. Claimant identification information required by this rule and the applicable form completion instructions is incorrect on the medical bill; or
6. Billing information required by this rule and the applicable form completion instructions is illegible on the medical bill; or
7. Billing information required by this rule and the applicable form completion instructions is omitted or incomplete on the medical bill.

(h) An insurer, claim administrator, service company/TPA or entity acting on behalf of the insurer shall establish and maintain a process by which medical bills that have been returned and written statements identifying the reason for return are compiled. The compiled information shall be sufficiently detailed to allow verification and review by the Division.

(12) A claim administrator, An insurer, service company/TPA or any entity acting on behalf of the insurer shall pay, adjust, disallow or deny billed charges within 45 calendar days from the Date Insurer Received Bill, pursuant to Section 440.20(2)(b), F.S.

(l) In the medical bill claims handling process, the receipt of medical bills may be based upon receipt by the insurer or there may be an “entity” acting on behalf of an insurer for purposes of receipt of medical bills. Likewise, the payment of medical bills may be based upon payment by the insurer or there may be an “entity” acting on behalf of an insurer for purposes of payment of medical bills. Therefore, to properly reflect receipt date and payment date of medical bills, the medical bill reporting process must accommodate various receipt and payment options.

1. The receipt and payment option utilized by an insurer and reported to the Division must meet one of the following:
   a. Both receipt and payment of medical bills are handled by the insurer. This option may be utilized only when the “date insurer received” is the date the insurer gained possession of the health care provider’s medical bill, and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any “entity” other than the insurer.
   b. Both receipt and payment of medical bills are handled by any “entity” acting on behalf of the insurer. This option may be utilized only when the “date insurer received” is the date the “entity” acting on behalf of the insurer gained possession of the health care provider’s medical bill, and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.
   c. Receipt of medical bills is handled by the insurer and payment of medical bills is handled by the “entity” acting on behalf of the insurer. This option may be utilized only when the “date insurer received” is the date the insurer gained possession of the health care provider’s medical bill, and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any “entity” other than the insurer.
d. Receipt of medical bills is handled by any “entity” acting on behalf of the insurer and payment of medical bills is handled by the insurer. This option may be utilized only when the “date insurer received” is the date the “entity” acting on behalf of the insurer gained possession of the health care provider’s medical bill, and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.

2. The insurer must:
   a. Document the option(s) selected in subparagraph (5)(l)1. of this rule,
   b. Document the specific effective date for each option selected,
   c. Document the specific role of each “entity” acting on the insurers behalf in the option selected,
   d. Make this written documentation available to the Division for audit purposes pursuant to Section 440.525, F.S.,
   e. Maintain written documentation from the “entity” acknowledging its responsibilities concerning “date insurer received” and “date insurer paid” for each option when the insurer selects options b., c., or d. from subparagraph (5)(l)1. of this rule, and
   f. Maintain written documentation identifying the applicability of the options selected in sufficient detail to allow verification of the coding of each medical bill under subparagraph (5)(l)4. of this rule.

3. An insurer and entity may select multiple options for medical bill claims handling between the insurer and the entity based on business practices or whether medical bills are submitted to the insurer electronically or on paper.

4. The option in subparagraph (5)(l)1. of this rule selected by the insurer must be identified on each medical report electronic submission to the Division and must utilize the following coding methodology:
   a. If the “date insurer received” is the date the insurer gains possession of the health care provider’s medical bill and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code “x” 1 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code “x” 1 to the Division, the insurer is declaring that no “entity” as defined in paragraph (1)(t) of this rule is involved in the medical bill claims-handling processes related to “date insurer received” or “date insurer paid”.
   b. If the “date insurer received” is the date the “entity” acting on behalf of the insurer gains possession of the health care provider’s medical bill and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer, then Payment Code “x” 2 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code “x” 2 to the Division, the insurer is declaring that the specified “entity” as defined in paragraph (1)(t) of this rule is acting on behalf of the insurer for purposes of the medical bill claims-handling processes related to “date insurer received” and “date insurer paid”.
   c. If the “date insurer received” is the date the insurer gains possession of the health care provider’s medical bill and “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer, then Payment Code “x” 3 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical Implementation EDI Guide (MEIG).) When submitting Payment Code “x” 3 to the Division, the insurer is declaring that no “entity” as defined in paragraph (1)(t) of this rule is involved in the medical bill claims-handling process related to “date insurer received”.
   d. If the “date insurer received” is the date the “entity” acting on behalf of the insurer gains possession of the health care provider’s medical bill and the “date insurer paid” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code “x” 4 must be transmitted on each individual form-type electronic submission. (“x” must equal ‘R’, ‘M’ or ‘C’ as denoted in Appendix D of the date-appropriate Florida Medical Implementation EDI
Guide (MEIG). When submitting Payment Code “x” 4 to the Division, the insurer is declaring that no “entity” as defined in paragraph (1)(t) is involved in the medical bill claims handling processes related to “date insurer paid”.

(m) An insurer, service company/TPA or any entity acting on behalf of the insurer, when reporting paid medical claims data to the Division, shall report the dollar amount paid by the insurer or reimbursed to the employee, the employer or other insurer for healthcare service(s) or supply(s). When reporting disallowed or denied charges, the dollar amount paid shall be reported as $0.00.

(n) An insurer, service company/TPA or any entity acting on behalf of the insurer is not required to report electronically all medical payment data to the Division, those payments made for federal facilities billing on their usual form, for duplicate medical bills, for medical bills outside the authority of Florida’s workers’ compensation system, or for health care providers in subparagraph (4)(b)15 who bill on their invoice or letterhead.

(13)(o) A submitter, filing electronically, shall submit to the Division the Explanation of Bill Review (EOBR) code(s), relating to the adjudication of each line item billed and:

1. Maintain the EOBR in a format that can be legibly reproduced, and
2. When reporting production data with the Medical Data System in the Claim Record Layout Revision “E” as required in paragraph (6)(f) of this rule, the insurer shall comply with the following instructions pertaining to EOBRs: In completing an Explanation of Bill Review (EOBR), a claim administrator shall, for each line item billed, select the EOBR code(s) from the list below which identifies(y) the reason(s) for the insurer’s reimbursement decision for each line item.

(a) The claim administrator may utilize up to three EOBR codes for each line item billed. When utilizing more than one EOBR code, the claim administrator shall list the EOBR codes that describe the basis for its reimbursement decision in descending order of importance. An insurer, service company/TPA or any entity acting on behalf of the insurer shall submit to the Division the Explanation of Bill Review (EOBR) code, relating to the adjudication of each line item billed, in descending order of importance. The EOBR code list is as follows:

(b) The EOBR code list is as follows:

06 – Payment disallowed: location of service(s) is not appropriate for the level of service(s) billed.
10 – Payment denied: compensability: total compensability denied or the injury or illness for which service was rendered is not compensable (Insurer must specify which).
21 – Payment disallowed: medical necessity: medical records reflect no physician’s order was given for service rendered or supply provided.
22 – Payment disallowed: medical necessity: medical records reflect no physician’s prescription was given for service rendered or supply provided.
23 – Payment disallowed: medical necessity: diagnosis does not support the service rendered or service is unrelated to the compensable injury or illness.
24 – Payment disallowed: medical necessity: service rendered was not therapeutically appropriate.
25 – Payment disallowed: medical necessity: service rendered was experimental, investigative or research in nature.
26 – Payment disallowed: service rendered by healthcare practitioner outside scope of practitioner’s licensure.
30 – Payment disallowed: lack of authorization: no authorization given for service rendered or notice provided for emergency treatment pursuant to subsection 440.13(3), F.S.
34 – Payment disallowed: no modification to the information provided on the medical bill. No payment made pursuant to contractual arrangement.
38 – Payment disallowed: insufficient documentation: documentation does not support this supply was dispensed to the patient.
39 – Payment disallowed: insufficient documentation: documentation does not support this medication was dispensed to the patient.
40 – Payment disallowed: insufficient documentation: documentation does not substantiate the service billed was rendered.
41 – Payment disallowed: insufficient documentation: level of evaluation and management service not supported by
documentation. (Insurer shall specify missing components of evaluation and management code description.)

42 – Payment disallowed: insufficient documentation: intensity of physical medicine and rehabilitation
service not supported by documentation.

43 – Payment disallowed: insufficient documentation: frequency of service not supported by
documentation.

44 – Payment disallowed: insufficient documentation: duration of service not supported by
documentation.

45 – Payment disallowed: insufficient documentation: fraud statement not provided pursuant to subsection
Section 440.105(7), F.S.

46 – Payment disallowed: insufficient documentation: required itemized statement not submitted with the medical bill.

47 – Payment disallowed: insufficient documentation: invoice or certification not submitted for implant.

48 – Payment disallowed: insufficient documentation: invoice not submitted for supplies.

49 – Payment disallowed: insufficient documentation: invoice not submitted for medication.

50 – Payment disallowed: insufficient documentation: specific documentation requested in writing at the time of authorization not
submitted with the medical bill. (Insurers shall specify omitted documentation.)

51 – Payment disallowed: insufficient documentation: required DFS-F5-DWC-25 not submitted.

52 – Payment disallowed: insufficient documentation: supply(ies) incidental to the procedure. (Incidental supply shall be
specified. Insurer must specify which supply is incidental to which procedure.)

53 – Payment disallowed: insufficient documentation: required operative report not submitted with the medical bill.

54 – Payment disallowed: insufficient documentation: required narrative report not submitted with the medical bill.

59 – Payment disallowed: billing error: Correct Coding Initiative guidelines indicate this code is mutually exclusive to code
XXXXX billed for service(s) provided on the same day (Insurer must specify inclusive procedure code).

60 – Payment disallowed: billing error: line item service previously billed and reimbursement decision previously rendered. (Use
EOBR Code 61 when all lines on bill are disallowed as duplicates. Do not transmit bill electronically to the Division.)

61 – Payment disallowed: billing error: duplicate bill. (Shall not be transmitted electronically to the Division.)

62 – Payment disallowed: billing error: incorrect procedure, modifier, units, supply code or NDC number.

63 – Payment disallowed: billing error: service billed is integral component of another procedure code. (shall Insurer must specify
inclusive procedure code.)

64 – Payment disallowed: billing error: service “not covered” under applicable workers’ compensation reimbursement manual.

65 – Payment disallowed: billing error: multiple providers billed on the same form.

66 – Payment disallowed: billing error: omitted procedure, modifier, units, or supply code or NDC number.

67 – Payment disallowed: billing error: Same service billed multiple times on same date of service.

68 – Payment disallowed: billing error: Rental value has exceeded purchase price per written fee agreement.

70 – Payment disallowed: billing error: omitted or incorrect/invalid Original Manufacturer’s NDC Number or
incorrect/invalid Repackaged NDC Number (carrier shall specify which) (do not use when a Repackaged NDC Number
Correct Coding Initiative guidelines indicate this code is not a comprehensive component of code XXXXX billed, see EOBR Code 98) for
service(s) provided on the same day (Insurer must specify inclusive procedure code.)

71 – Payment adjusted: insufficient documentation: level of evaluation and management service not supported by documentation.

72 – Payment adjusted: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by
documentation.

73 – Payment adjusted: insufficient documentation: frequency of service not supported by documentation.

74 – Payment adjusted: insufficient documentation: duration of service not supported by documentation.
75 – Payment adjusted: insufficient documentation: specific documentation requested in writing at the time of authorization not submitted with the medical bill.

80 – Payment adjusted: billing error: correction of procedure, modifier, supply code, units, or NDC number (shall not be used with repackaged medications).

81 – Payment adjusted: billing error: payment modified pursuant to a charge audit.

83 – Payment adjusted: medical benefits paid apportioning out the percentage of the need for such care attributable to preexisting condition (paragraph Section 440.15(5)(b), F.S.).

84 – Payment adjusted: co-payment applied pursuant to paragraph Section 440.13(14)(c), F.S.

85 – Payment adjusted: no modification to the information provided on the medical bill. Payment made pursuant to a fee agreement between the health care provider and the carrier.

86 – Payment adjusted: billing error; repackaged medication; correction of NDC number dispensed or reimbursed pursuant to 440.13(12)(c), F.S. (Insurer shall indicate the corrected NDC number dispensed or reimbursed).

90 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers’ Compensation Health Care Provider Reimbursement Manual.

91 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers’ Compensation Reimbursement Manual for Ambulatory Surgical Centers.

92 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers’ Compensation Reimbursement Manual for Hospitals.

93 – Paid: no modification to the information provided on the medical bill: payment made pursuant to written contractual arrangement (network or PPO name required).


95 – Paid: Reimbursement Dispute Resolution: payment made pursuant to receipt of a Determination or Final Order on a Petition for Resolution of Reimbursement Dispute, pursuant to subsection Section 440.13(7), F.S.

96 – Paid: Payment made pursuant to a write-off by a health care provider self-insured employer.

97 – Paid: no modification to the information provided on the medical bill; repackaged medication; reimbursed at repackaged methodology pursuant to paragraph 440.13(12)(c), F.S.

98 – Paid: no modification to the information provided on the medical bill; dispensed medication; billed Original NDC only; reimbursed pursuant to paragraph 440.13(12)(c), F.S.

(14) A claim administrator An insurer, service company/TPA, submitter or any entity acting on behalf of the insurer shall make available to the Division, upon request and without charge, a legibly reproduced copy of the electronic form equivalents or Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-25, DFS-F5-DWC-90, supplemental documentation, proof of payment, EOBR and the insurer written documentation required in subparagraphs (5)(j)6. and (5)(l)2. of this rule.

(q) An insurer, service company/TPA or any entity acting on behalf of the insurer to pay, adjust, disallow or deny a filed bill shall submit to the health care provider an Explanation of Bill Review 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 Rule 69L-7.740(13), F.A.C., paragraph (o) of this section, and shall include the insurer name, Division issued Insurer Code Number, insurer number and corresponding insurer mailing address. However, an insurer may choose to append an internal reason code to the EOBR it submits to the health care provider, when utilizing an EOBR code set forth in Rule 69L-7.740(13), F.A.C., paragraph (o) that includes a code descriptor requiring the insurer to provide additional specification. A claim administrator An insurer, service company/TPA 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. An EOBR shall 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” for the purpose of receiving the petitioner’s service of a copy of a petition for reimbursement dispute resolution by certified mail, pursuant to paragraph 440.13(7)(a), F.S. The requirements of this subpart paragraph do not apply to adjudication of a bill for pharmaceutical services provided by a pharmacist or pharmacy licensed under Chapter 465, F.S., and billed on a Form DFS-F5-DWC-10 or its electronic equivalent, where, prior to the services being rendered, a binding contract exists between the claim administrator, service company/TPA or any entity acting on behalf of the insurer, and the pharmacist or pharmacy or its representative that governs and specifies the amount to be paid by or on behalf of the insurer for the services.

(15r) Copies of hospital medical records shall be subject to charges allowed pursuant to section 395.3025, F.S. and section 440.13, F.S.

69L.(e) When an insurer, service company/TPA or any entity acting on behalf of the insurer renders reimbursement as pre-payment for medical services, goods or supplies, reimbursement of employee payment or payment for pharmacy first-fill services, the required data elements, optionally including the appropriate Pre-Payment/Employee Payment/First Fill Indicator as described in the MEIG, shall be submitted to the Division within 45 calendar days of the insurer, service company/TPA or any entity acting on behalf of the insurer receipt date of the medical billing form, regardless of the date of payment.

(t) When an insurer, service company/TPA or any entity acting on behalf of the insurer renders reimbursement following receipt of a Determination or Final Order in response to a petition to resolve a reimbursement dispute filed pursuant to Section 440.13(7.750), F.S., the insurer shall:

1. Submit the required data elements to the Division within 45 calendar days of rendering reimbursement; and
2. Submit the data as a replacement submission pursuant to the date-appropriate MEIG; and
3. Submit the cumulative, not the supplemental, payment information at the line-item level utilizing EOBR 95 for each line-item reflecting a payment amount differing from the payment amount reported on the original submission; and
4. Report the “Date Insurer Received” as 22 days after the date the Determination was received by certified mail, in instances where the insurer has waived its rights under Chapter 120, F.S., or report the “Date Insurer Received” as the date the carrier received the Final Order by certified mail, in instances where the insurer has invoked its rights pursuant to Chapter 120, F.S., whichever occurs first.

(u) When an insurer, service company/TPA, submitter or any entity acting on behalf of the insurer has reported medical claims data to the Division which was not required, the insurer shall withdraw the previously reported data as described in the MEIG.

(v) When an insurer, service company/TPA, any entity acting on behalf of the insurer renders reimbursement for multiple bills received from a health care provider, the insurer shall report required data elements to the Division for each individual bill, including “Date Insurer Received” and “Date Insurer Paid”, submitted by the health care provider and shall not combine multiple bills received from a health care provider into a single medical bill data submission.

(6) Insurer Electronic Medical Report Filing to the Division.

(1a) Effective 3/16/05, all required medical reports shall be electronically filed with the Division by all insurers.

(2b) Required data elements shall be submitted in compliance with the instructions and formats as set forth in the date-appropriate Florida Medical EDI Implementation Guide (MEIG).

(3e) The Division will notify the Sender insurer on the “Medical Bill Acknowledgement Processing Report” of the corrections necessary for rejected medical reports to be electronically re-filed with the Division. An insurer shall ensure correct and re-file all rejected medical reports are corrected and resubmitted successfully to meet the filing requirements of Rule 69L-.750 paragraph(5), F.A.C(e) of this rule.
(4) Any Sender who experiences a catastrophic event resulting in the insurer’s failure to meet the reporting requirements in Rule 69L-7.750, F.A.C., (5), of this rule, shall submit a written or electronic request within 15 business days after the catastrophic event to the Division for approval to submit in an alternative reporting method and an alternative filing timeline. The request shall contain a detailed explanation of the nature of the event, date of occurrence, and measures being taken to resume electronic submission. The request shall also provide an estimated date by which electronic submission of affected EDI filings will be resumed. Approval shall be obtained from the Division’s Bureau of Data Quality and Collection, 200 East Gaines Street, Tallahassee, Florida 32399-4226. Approval to submit in an alternative reporting method and an alternative filing timeline shall be granted by the Division if a catastrophic event prevents electronic submission.

(5a) Submitters who have been approved for reporting production data with the Medical Data System (Record Layouts 09, 10, 11 and 90) shall begin testing 165 days after the effective date of this rule.

(5b) Senders with Sender FL ID numbers 200 - 899 shall begin testing 120 days after the effective date of this rule.

(6) Each insurer shall be responsible for accurately completing the electronic record layout programming requirements for the reporting of the Medical EDI Bill Form DFS F5-DWC-9 Record Layout — Revision F for Records 09, “E”, Form DFS F5-DWC-10, 11 and 90 Record Layout — Revision “E”, Form DFS F5-DWC-11 Record Layout — Revision “E” and Form DFS F5-DWC-90 Record Layout — Revision “E” in accordance with the Florida Medical EDI Implementation Guide (MEIG) 2010, to the Division in accordance with the phase-in schedule as denoted below.

(a) Senders with Sender FL ID numbers 001 - 199 shall begin testing 120 days after the effective date of this rule in subparagrapghs 1., 2., and shall complete the testing process within 15 business days after the Division’s Bureau of Data Quality and Collection, 200 East Gaines Street, Tallahassee, Florida 32399-4226. Approval to submit in an alternative reporting method and an alternative filing timeline shall be granted by the Division if a catastrophic event prevents electronic submission.

(b) Senders with Sender FL ID numbers 200 - 899 shall begin testing 165 days after the effective date of this rule.

(6) Each insurer shall be responsible for ensuring accurately completing the accurate completion in accordance with the Florida Medical EDI Implementation Guide (MEIG) 2010, to the Division in accordance with the phase-in schedule as denoted below.

(a) Senders with Sender FL ID numbers 001 - 199 shall begin testing 120 days after the effective date of this rule in subparagrapghs 1., 2., and shall complete the testing process within 15 business days after the Division’s Bureau of Data Quality and Collection, 200 East Gaines Street, Tallahassee, Florida 32399-4226. Approval to submit in an alternative reporting method and an alternative filing timeline shall be granted by the Division if a catastrophic event prevents electronic submission.

(b) Senders with Sender FL ID numbers 200 - 899 shall begin testing 165 days after the effective date of this rule.

1. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout — Revision “D”), between 04/01/2007 and 06/15/2007 shall begin testing on 03/01/2010 and shall complete the testing process with the new Revision “E” record layouts no later than 04/12/2010.

2. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout — Revision “D”), between 06/16/2007 and 12/31/2007 shall begin testing on 04/13/2010 and shall complete the testing process with the new Revision “E” record layouts within 210 days after the effective date of this rule, no later than 05/25/2010.
(c) Submitters who have been approved for reporting production data with Sender FL ID numbers 900 and above the Medical Data System (Record Layout – Revision “D”), between 08/08/2007 and the effective date of this rule shall begin testing 210 days after the effective date of this rule on 05/26/2010 and shall complete the testing process with the new Revision “FE” record layouts within 255 days after the effective date of this rule, no later than 07/07/2010.

(d) The Division will, resources permitting, allow Senders/submitters that volunteer to complete the test transmission processes earlier than the schedule denoted above. Each voluntary Sender/submitter shall still have 45 days from the start date of testing six weeks to complete the test transmission to production transmission processes, for all Medical EDI Bill Recordseletronic form equivalents, that comply with requirements set forth in the Florida Workers’ Compensation Medical EDI Implementation Guide (MEIG), 2010.

(7) Senders/Submit All submitters shall be in production with the new Revision “E” record layouts on 07/08/2010.

(h) Submitters who do not accurately complete testing and maintain electronic record layout programming requirements in accordance with the Florida Medical EDI Implementation Guide (MEIG) of this rule shall not submit Revision F medical reports electronically until the Sender/submitter has been approved for reporting production data with the Division/Medical Data System as necessary to meet the filing requirements of Rule 69L-7.750, paragraph (5), F.A.C.(e) of this rule.

(8)(a) In the medical bill claims-handling process, the receipt of medical bills may be based upon receipt by the insurer or an “entity” acting on behalf of an insurer. Likewise, the payment of medical bills may be based upon payment by the insurer or an “entity” acting on behalf of an insurer. Therefore, to properly reflect “Date Insurer Received Bill” and “Date Insurer Paid Bill”, the insurer or entity acting on behalf of the insurer, shall be limited to the receipt and payment options of this subpart for the reporting of a medical bill:

1. Both receipt and payment of medical bills are handled by the insurer. This option may be utilized only when the “Date Insurer Received Bill” is the date the insurer gained possession of the health care provider’s medical bill, and the “Date Insurer Paid Bill” is the date the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any “entity” other than the insurer.

2. Both receipt and payment of medical bills are handled by any “entity” acting on behalf of the insurer. This option may be utilized only when the “Date Insurer Received Bill” is the date the “entity” acting on behalf of the insurer gained possession of the health care provider’s medical bill, and the “Date Insurer Paid Bill” is the date an entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.

3. Receipt of medical bills is handled by the insurer and payment of medical bills is handled by the “entity” acting on behalf of the insurer. This option may be utilized only when the “Date Insurer Received Bill” is the date the insurer gained possession of the health care provider’s medical bill, and the “Date Insurer Paid Bill” is the date the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings to any “entity” other than the insurer.

4. Receipt of medical bills is handled by any “entity” acting on behalf of the insurer and payment of medical bills is handled by the insurer. This option may be utilized only when the “Date Insurer Received Bill” is the date the “entity” acting on behalf of the insurer gained possession of the health care provider’s medical bill, and the “Date Insurer Paid Bill” is the date the insurer mails, transfers or electronically transmits payment to the health care provider or the health care provider representative. This option may not be utilized when a health care provider is required by the insurer to submit medical billings directly to the insurer.

(b) An insurer and entity may select multiple options for medical bill claims handling between the insurer and the entity based on business practices or whether medical bills are submitted to the insurer electronically or on paper.
The option in Rule 69L-7.750(8)(a), F.A.C., selected by the insurer shall be identified on each medical report electronic submission to the Division and shall utilize the following coding methodology:

1. If the “Date Insurer Received Bill” is the date the insurer gains possession of the health care provider’s medical bill and the “Date Insurer Paid Bill” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code “x” 1 shall be transmitted on each individual electronic form equivalent transaction. (“x” shall equal ‘R’, ‘M’ or ‘C’ as denoted in the data dictionary of the Florida Medical EDI Implementation Guide (MEIG).) When submitting Payment Code “x” 1 to the Division, the insurer is declaring that no “entity” as defined in Rule 69L-7.710(1)(x), F.A.C., of this rule is involved in the medical bill claims-handling processes related to “Date Insurer Received Bill” or “Date Insurer Paid Bill”.

2. If the “Date Insurer Received Bill” is the date the “entity” acting on behalf of the insurer gains possession of the health care provider’s medical bill and the “Date Insurer Paid Bill” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer, then Payment Code “x” 2 shall be transmitted on each individual electronic form equivalent transaction. (“x” shall equal ‘R’, ‘M’ or ‘C’ as denoted in the data dictionary of the Florida Medical EDI Implementation Guide (MEIG).) When submitting Payment Code “x” 2 to the Division, the insurer is declaring that the specified “entity” as defined in Rule 69L-7.710(1)(x), F.A.C., of this rule is acting on behalf of the insurer for purposes of the medical bill claims-handling processes related to “Date Insurer Received Bill” and “Date Insurer Paid Bill”.

3. If the “Date Insurer Received Bill” is the date the insurer gains possession of the health care provider’s medical bill and “Date Insurer Paid Bill” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the “entity” acting on behalf of the insurer, then Payment Code “x” 3 shall be transmitted on each individual electronic form equivalent transaction. (“x” shall equal ‘R’, ‘M’ or ‘C’ as denoted in the data dictionary of the Florida Medical EDI Implementation Guide (MEIG).) When submitting Payment Code “x” 3 to the Division, the insurer is declaring that no “entity” as defined in Rule 69L-7.710(1)(x), F.A.C., is involved in the medical bill claims-handling process related to “Date Insurer Received Bill”.

4. If the “Date Insurer Received Bill” is the date the the “entity” acting on behalf of the insurer gains possession of the health care provider’s medical bill and the “Date Insurer Paid Bill” is the date the health care provider’s payment is mailed, transferred or electronically transmitted by the insurer, then Payment Code “x” 4 shall be transmitted on each individual form electronic form equivalent transaction. (“x” shall equal ‘R’, ‘M’ or ‘C’ as denoted in the data dictionary of the Florida Medical EDI Implementation Guide (MEIG).) When submitting Payment Code “x” 4 to the Division, the insurer is declaring that no “entity” as defined in Rule 69L-7.710(1)(x), F.A.C., is involved in the medical bill claims-handling processes related to “Date Insurer Paid Bill”.

9. A claim administrator or any entity acting on behalf of the insurer, when reporting paid medical claims data to the Division, shall report the dollar amount paid by the insurer or reimbursed to the employee, the employer or other insurer for healthcare service(s) or supply(ies). When reporting disallowed or denied charges, the dollar amount paid shall be reported as $0.00.

10. A claim administrator or any entity acting on behalf of the insurer is not required to report electronically as medical payment data to the Division, those payments made for federal facilities billing on their usual form, for duplicate medical bills, for medical bills outside the authority of Florida’s workers’ compensation system, or for health care providers in Rule 69L-7.730(2)(o), F.A.C., who bill on their invoice or letterhead.

11. A claim administrator or any entity acting on behalf of the insurer filing electronically, shall submit to the Division the Explanation of Bill Review (EOBR) code(s), relating to the adjudication of each line item billed and:

(a) Maintain the EOBR in a format that can be legibly reproduced, and
(b) When reporting production data in accordance with the Florida Medical EDI Implementation Guide (MEIG) as required in Rule 69L-7.750(6), F.A.C., the insurer shall comply with the EOBR instructions contained in Rule 69L-7.740(13)

12. A claim administrator, sender or any entity acting on behalf of the insurer shall make available to the Division, upon request and without charge, a legibly reproduced copy of the electronic form equivalents of Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or
insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-25, DFS-F5-DWC-90, supplemental documentation, proof of payment, EOBR and the insurer written documentation required in Rules 69L-7.740(8)(b)(6) and 69L-7.750(8)(b), F.A.C.

(13) When a claim administrator or any entity acting on behalf of the insurer renders reimbursement following receipt of a Determination or Final Order in response to a petition to resolve a reimbursement dispute filed pursuant to subsection 440.13(7), F.S., the insurer shall:

(a) Submit the required data elements to the Division within 45 days of rendering reimbursement; and

(b) Submit the data as a replacement submission pursuant to the MEIG; and

(c) Submit the cumulative, not the supplemental, payment information at the line-item level utilizing EOBR code 95 for each line-item reflecting a payment amount differing from the payment amount reported on the original submission; and

(d) Report the “Date Insurer Received Bill” as 22 days after the date the Determination was received by certified mail, in instances where the insurer has waived its rights under Chapter 120, F.S., or report the “Date Insurer Received Bill” as the date the insurer received the Final Order by certified mail, in instances where the insurer has invoked its rights pursuant to Chapter 120, F.S., whichever occurs first.

(14) When a claim administrator or any entity acting on behalf of the insurer has reported medical claims data to the Division which were not required, the claim administrator or any entity acting on behalf of the insurer shall withdraw the previously reported data as described in the MEIG.

(15) When an insurer, claim administrator, or any entity acting on behalf of the insurer renders reimbursement for multiple bills received from a health care provider, the insurer shall report required data elements to the Division for each individual bill, including “Date Insurer Received Bill” and “Date Insurer Paid Bill”, submitted by the health care provider and shall not combine multiple bills received from a health care provider into a single medical bill transaction.