

69L-7.602 Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule.

(1) Definitions. As used in this rule:

(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) "Agency" means the Agency for Health Care Administration as defined in Section 440.02(3), F.S.~~

~~(c)(d)~~ "Ambulatory Surgical Center" is defined in Section 395.002(3), F.S.

~~(d)(e)~~ "Billing" means the process by which a health care provider submits a medical claim form or medical bill to an insurer, 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.

~~(e)(f)~~ "Catastrophic Event" means the occurrence of an event outside the control of an insurer, submitter, service company/third party 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 an insurer, submitter, service company/third party 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 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.

~~(f)(g)~~ "Charges" means the dollar amount billed.

~~(g)(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.

~~(h)(4)~~ “Claims-Handling Entity File Number” means the number assigned to the claim file by the insurer or service company/third party administrator for purposes of internal tracking.

~~(i)(4)~~ “Current Dental Terminology” (CDT) means the American Dental Association’s reference document containing descriptive terms to identify codes for billing and reporting dental procedures.

~~(j)(4)~~ “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.

~~(k)(4)~~ “Date Insurer Paid” or “Date Insurer Paid, Adjusted, Disallowed or Denied” means the date the 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” or “Date Insurer Paid, Adjusted, Disallowed or Denied” means the date the insurer, 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 paragraph (5)(l) for the requirement to accurately report the “date insurer paid”.

~~(l)(m)~~ “Date Insurer Received” 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 insurer, service company/third party administrator or any entity acting on behalf of the insurer. See paragraph (5)(l) for the requirement to accurately report the “date insurer received”. If a medical bill meets any of the criteria in paragraph (5)(j) of this rule and possession of the form is relinquished by the 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” shall not apply to the medical bill as submitted.

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

~~(n)(o)~~ “Department” means Department of Financial Services (DFS) as defined in Section 440.02(12), F.S.

~~(o)(4)~~ “Disallow” or “Disallowed” means payment is not made because the service rendered has not been substantiated for reasons of medical necessity, insufficient documentation, lack of authorization or billing error.

~~(p)(4)~~ “Division” means the Division of Workers’ Compensation (DWC) as defined in Section 440.02(14), F.S.

~~(q)(4)~~ “Electronic Filing” means the computer exchange of medical data from a submitter to the Division in the standardized format defined in the Florida Medical EDI Implementation Guide (MEIG).

~~(r)(4)~~ “Electronic Form Equivalent” means the format, provided in the Florida Medical EDI Implementation Guide (MEIG) to be used when a submitter 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.

~~(s)(4)~~ “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.

~~(t)(4)~~ “Entity” means any party involved in the processing, adjudication or payment of medical bills on behalf of the insurer, provision of or the payment for medical services, care or treatment rendered to the injured employee, excluding the insurer, service company/third party administrator or health care provider as identified in this section.

~~(u)(4)~~ “Explanation of Bill Review” (EOBR) means the notice of payment or notice of adjustment, disallowance or denial sent 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 section paragraph (5)(4) of this rule.

~~(v)~~ “Explanation of Bill Review Code” (EOBR Code) means a code listed in subparagraph (5)(o)2. of this rule that describes the basis for the reimbursement decision of an insurer, service company/TPA or any entity acting on behalf of the insurer.

(w) “Florida Medical EDI Implementation Guide (MEIG)” is the Florida Division of Workers’ Compensation’s reference document containing the specific electronic formats and data elements required for insurer reporting of medical data to the Division.

(x) “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.

(y) “Health Care Provider” is defined in Section 440.13(1)(h), F.S.

(z) “Home Health Agency” is defined in Section 400.462(12), F.S. “Hospital” is defined in Section 395.002(13), F.S.

(aa) “Home Medical Equipment Provider” (sometimes referred to as durable medical equipment (DME) provider) is defined in Section 400.925(7), F.S. “ICD-9-CM International Classification of Diseases” (ICD-9) is the U.S. Department of Health and Human Services’ reference document listing the official diagnosis and inpatient procedure code sets.

(bb) “Hospital” is defined in Section 395.002(12), F.S. “Insurer” is defined in Section 440.02(38), F.S.

(cc) “ICD-9-CM International Classification of Diseases” (ICD-9) is the U.S. Department of Health and Human Services’ reference document listing the official diagnosis and inpatient procedure code sets. “Insurer Code Number” means the number the Division assigns to each individual insurer, self-insured employer or self-insured fund.

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

(ee) “Insurer Code Number” means the number the Division assigns to each individual insurer, self-insured employer of self-insured fund. “Medical Bill” means the document or electronic 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 paragraph (4)(b) of this rule.

(ff) “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 “Medically Necessary” or “Medical Necessity” is defined in Section 440.13(1)(l), F.S.

(gg) “Medical Bill” means the document or electronic 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 paragraph (4)(b) of this rule.

~~“NDC Number” means the 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. 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 (-).~~

(hh) “Medically Necessary” or “Medical Necessity” is defined in Section 440.13(1)(l), F.S. “Pay” or “Paid” means payment is made applying the applicable reimbursement formula to the medical bill as submitted.

(ii) “NDC Number” means the 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. 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 (-). “Physician” is defined in Section 440.13(1)(q), F.S.

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

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

(ll) “Physician” is defined in Section 440.13(1)(q), F.S. “Service Company/Third Party Administrator (TPA)” means a party that has contracted with an insurer for the purpose of providing services necessary to adjust workers’ compensation claims on the insurer’s behalf.

(mm) “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. “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.~~

(nn) “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). ~~“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.~~

(oo) “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. “UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, November 2006” (UB-92 Manual) is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-92 HCFA-1450, Uniform Bill, Rev. 1992).

(pp) “Service Company/Third Party Administrator (TPA)” means a party that has contracted with an insurer for the purpose of providing services necessary to adjust workers’ compensation claims on the insurer’s behalf. “UB-04 Manual” means the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2007, which is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2007).

(qq) “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.

(rr) “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.

(ss) “UB-04 Manual” means the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2010⁹, which is the reference document providing billing and reporting completion instructions for the Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006).

(2) Forms Incorporated by Reference for Medical Billing, Filing and Reporting.

~~(a)1. Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 12/90); Form DFS-F5-DWC-9-A (Completion Instructions for Form DFS-F5-DWC-9: comprised of three sets of completion instructions for use by health care providers, ambulatory surgical centers, and work hardening and pain management programs), Rev. 5/26/05. Effective to bill for dates of service up to and including 03/31/07.~~

~~(a)2. Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 08/05); Form DFS-F5-DWC-9-B (Completion Instructions for Form DFS-F5-DWC-9: comprised of three sets of completion instructions; one for use by health care providers, Rev. 3/1/2009; one each for ambulatory surgical centers, and work hardening and pain management programs), Rev. 1/1/07. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~~~

~~(b)1. Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form), Rev. 2/14/06. Effective to bill for dates of service up to and including 3/31/07.~~

~~(b)2. Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Equipment & Supplies Form), Rev. 3/1/09 ~~4/1/07~~. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~~~

~~(c)1. Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2002); Form DFS-F5-DWC-11-A (Completion Instructions for Form DFS-F5-DWC-11), Rev. 5/26/05. Effective to bill for dates of service up to and including 3/31/07.~~

~~(c)2. Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2006); Form DFS-F5-DWC-11-B (Completion Instructions for Form DFS-F5-DWC-11), Rev. 1/1/07. ~~May be used to bill for dates of service up to and including 3/31/07 and shall be used to bill for dates of service on and after 4/1/07.~~~~

(d) Form DFS-F5-DWC-25 (Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form), Rev. 1/31/08 2/14/06.

~~(e)1. Form DFS-F5-DWC-90 (UB-92 HCFA-1450, Uniform Bill, Rev. 1992). Effective for submissions up to and including 5/22/07.~~

~~(e)2. 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 for use by hospitals), Rev. 1/1/09; ~~4/1/07~~; Form DFS-F5-DWC-90-C (Completion Instructions for Form DFS-F5-DWC-90 for use by Ambulatory Surgical~~

Centers), New 1/1/09; Form DFS-F5-DWC-90-D (Completion Instructions for Form DFS-F5-DWC-90 for use by Home Health Agencies), New 1/1/09; FS-F5-DWC-90-E (Completion Instructions for Form DFS-F5-DWC-90 for use by Nursing Homes Facilities), New 1/1/09. May be used to bill for submissions between 3/1/07 and 5/22/07 and shall be used to bill for submissions on and after 5/23/07.

(f) Obtaining Copies of Forms and Instructions.

1. A copy of either revision of the Form DFS-F5-DWC-9 can be obtained from the AMA CMS web site: <https://catalog.ama-assn.org/Catalog> <http://www.cms.hhs.gov/forms/>. Completion instructions (DFS-F5-DWC-9-B) on of the form can be obtained from the Department of Financial Services/Division of Workers' Compensation (DFS/DWC) web site: <http://www.myfloridacfo.com/WC/forms.html> <http://www.fldfs.com/WC/forms.html#7>.

2. A copy of either revision of the Form DFS-F5-DWC-10 and completion instructions for either revision of the form can be obtained from the DFS/DWC web site: <http://www.myfloridacfo.com/WC/forms.html> <http://www.fldfs.com/WC/forms.html#7>.

3. A copy of either revision of the Form DFS-F5-DWC-11 can be obtained from the American Dental Association web site: <http://www.ada.org/>. Completion instructions for either revision of the form can be obtained from the DFS/DWC web site: <http://www.myfloridacfo.com/WC/forms.html> <http://www.fldfs.com/WC/forms.html#7>.

4. A copy of the Form DFS-F5-DWC-25 and completion instructions can be obtained from the DFS/DWC web site: <http://www.myfloridacfo.com/WC/forms.html> <http://www.fldfs.com/WC/forms.html#7>.

5. A copy of either revision of the Form DFS F5-DWC-90 can be obtained from the CMS web site: <http://www.cms.hhs.gov/forms/>. Completion instructions for Form DFS F5-DWC-90 (Rev. 1992) can be obtained from the UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. September 2006) and subparagraph (4)(b)4. of this rule. A copy of the Completion instructions for completion of Form DFS-F5-DWC-90 (Rev. 2006), Form DFS-F5-DWC-90-B (for hospitals) (Rev. 1/1/09 4/1/07), Form DFS-F5-DWC-90-C (for ASCs) (New 1/1/09), Form DFS-F5-DWC-90-D (for Home Health Agencies), Form DFS-F5-DWC-90-E (for Nursing Home Facilities),

New 1/1/09, can be obtained from the DFS/DWC web site: <http://www.myfloridacfo.com/WC/forms.html>
<http://www.fldfs.com/WC/forms.html#7>.

(g) In lieu of submitting a Form DFS-F5-DWC-10, when billing for drugs or medical supplies, alternate billing forms are acceptable if:

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

2. The form provides all information required to be submitted to the Division, pursuant to the date-appropriate 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.

(3) Materials Adopted by Reference. The following publications are incorporated by reference herein:

~~(a) UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. September 2006). A copy of this manual can be obtained from the Florida Hospital Association by calling (407)841-6230.~~

~~(b) The Florida Medical EDI Implementation Guide (MEIG), 2006, applicable for data submission until 7/1/07. The Florida Medical EDI Implementation Guide (MEIG), 2006 can be obtained from the DFS/DWC web site: http://www.fldfs.com/WC/edi_med.html.~~

~~(a)(e)~~ The American Medical Association Healthcare Common Procedure Coding System, Medicare's National Level II Codes (HCPCS), as adopted in Rule 69L-7.020, F.A.C.

~~(b)(d)~~ The Current Procedural Terminology (CPT[®]), as adopted in Rule 69L-7.020, F.A.C.

~~(c)(e)~~ The Current Dental Terminology (CDT-2005), as adopted in Rule 69L-7.020, F.A.C.

~~(d)(f)~~ The 2009~~7~~ ICD-9-CM Professional for Hospitals, Volumes 1, 2 and 3, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008~~6~~, Ingenix, Inc. (American Medical Association).

~~(e)(g)~~ The Physician ICD-9-CM 2009~~7~~, Volumes 1 & 2, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2008~~6~~, Ingenix, Inc. (American Medical Association).

~~(f)(h)~~ The American Medical Association's Guide to the Evaluation of Permanent Impairment, as adopted in Rule 69L-7.604, F.A.C.

~~(g)(4)~~ The Minnesota Department of Labor and Industry Disability Schedule, as adopted in Rule 69L-7.604, F.A.C.

~~(h)(4)~~ The Florida Impairment Rating Guide, as adopted in Rule 69L-7.604, F.A.C.

~~(i)(4)~~ The 1996 Florida Uniform Permanent Impairment Rating Schedule, as adopted in Rule 69L-7.604, F.A.C.

~~(j)(4)~~ National Uniform Billing Committee Official UB-04 Data Specifications Manual 20107, version 44.00, July 2009September 2006, as adopted by the National Uniform Billing Committee. A copy of this manual can be obtained from the National Uniform Billing Committee web site:

~~http://www.nubc.org/become.html http://www.nube.org/UB-04%20SUBSCRIPTION%20ORDER%20FORM.doc.~~

~~(k)(m)~~ The Florida Medical EDI Implementation Guide (MEIG), 20107, applicable for data submission on or after 4/2/07 and required for all data submission on or after 8/9/07. The Florida Medical EDI Implementation Guide (MEIG), 20107 can be obtained from the DFS/DWC web site:

~~http://www.myfloridacfo.com/WC/edi_med.html http://www.fdfs.com/WC/edi_med.html.~~

~~(l)~~ The Florida Workers' Compensation Reimbursement Manual for Hospitals, Rule 69L-7.501, F.A.C.

~~(m)~~ The Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-100, F.A.C.

~~(n)~~ The Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C.

~~(n)~~ Current Procedural Terminology (CPT[®]), 20097 Professional Edition, Copyright 2006, American Medical Association.

(4) Health Care Provider Responsibilities.

(a) Bill Submission/Filing and Reporting Requirements.

1. 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.

2. Each health care provider is responsible for submitting any ~~additional~~ 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 ~~or at the time a reimbursement request is received.~~

3. Each health care provider shall resubmit a medical claim form or medical bill with insurer requested documentation when the EOBR provides an explanation for the disallowed service disallowance based on the provider's failure to submit requested ~~lack of documentation submitted~~ with the medical bill.

4. 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 Any other reporting forms may not be used in lieu of or supplemental to the Form DFS-F5-DWC-25. Provider failure to accurately complete and submit the DFS F5 DWC 25, in accordance with the Form DFS F5 DWC 25 Completion/Submission Instructions adopted in this rule, may result in the Agency imposing sanctions or penalties pursuant to subsection 440.13(8), F.S. or subsection 440.13(11), F.S.~~

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

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

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

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

7. When requested by the 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 paragraph (4)(b) of this rule and the applicable reimbursement manual.

8. Each health care provider is responsible for correcting and resubmitting any billing forms returned by an insurer, service company/TPA or any entity acting on behalf of the insurer pursuant to paragraph (5)(j) of this rule.

9. 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.

10. 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.

(b) Special Billing Requirements.

1. When anesthesia services are billed on a Form DFS-F5-DWC-9, completion of the form must 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.

2. When an Certified Registered Nurse Anesthetist (CRNA) ~~Advanced Registered Nurse Practitioner (ARNP)~~ provides anesthesia services as a ~~Certified Registered Nurse Anesthetist~~, the CRNA ~~ARNP~~ 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.

3. Recognized practitioners, except physician assistants, advanced registered nurse practitioners, certified registered nurse anesthetists, who are salaried employees of an authorized treating physician and ~~Regardless of the employment arrangement under which the services are rendered or the party submitting the bill, the following health care providers, who render direct billable services for which reimbursement is~~ sought from an insurer, service company/TPA or any entity acting on behalf of the insurer, service company/TPA, shall report and bill for such services on a Form DFS-F5-DWC-9 by entering the employing physician's ~~and enter his/her~~ Florida Department of Health license number in Field 33b on the Form DFS-F5-DWC-9;

- ~~a. Any licensed physician; or~~
- ~~b. Any non-physician health care provider, including a physician assistant or an ARNP (not providing an anesthesia related service); or~~
- ~~c. Any licensed non-physician health care provider who is seeking reimbursement under his or her license number issued by the Florida Department of Health~~

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

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

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

II. Submit all specifically requested and additional applicable documentation requested at the time of authorization or certification required pursuant to Rule 69L-7.501, F.A.C.; and

III. 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;

IV. Make written entry “implant(s)” followed by the reimbursement amount calculated pursuant to Rule 69L-7.501, F.A.C., in Form Locator 80 of Form revision 2006 – ‘Remarks’ on the DFS-F5-DWC-90. or certification required pursuant to Rule 69L-7.501, F.A.C. When entering the CPT[®], HCPCS or unique workers’ compensation codes in Form Locator 44 on the Form DFS-F5-DWC-90, the hospital shall utilize CPT[®], HCPCS or unique workers’ compensation codes provided in the Florida Workers’ Compensation Health Care Provider Reimbursement Manual adopted in Rule 69L-7.501, F.A.C.

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

I. Enter the CPT[®], HCPCS or ~~unique~~ workers’ compensation unique code and the applicable CPT[®] or HCPCS modifier code (provided in the Florida Workers’ Compensation Health Care Provider Reimbursement Manual as incorporated for reference in Rule 69L-7.501, F.A.C.) in Form Locator 44 on the Form DFS-F5-DWC-90, when required pursuant to the UB-04 Manual where applicable to bill outpatient radiology, clinical laboratory and physical, occupational or speech therapy charges; and

II. Make written entry “scheduled” or “non-scheduled” in ~~Form Locator 84 of Form revision 1992 and in~~ Form Locator 80 of Form revision 2006 – ‘Remarks’ on the DFS-F5-DWC-90, when billing outpatient surgery or outpatient surgical services; and

~~III. Make written entry “implant(s)” followed by the reimbursement calculation made pursuant to Rule 69L-7.501, F.A.C., in Form Locator 84 of Form revision 1992 and in Form Locator 80 of Form revision 2006 “Remarks” on the DFS F5-DWC-90, directly after entry of “scheduled” or “non-scheduled”, when present;~~

~~III,IV.~~ Attach an itemized statement with charges based on the facility’s Charge Master ~~if there is no line item detail shown on the Form DFS F5-DWC-90;~~ and

~~IV,V.~~ Submit all applicable documentation ~~or certification~~ required pursuant to Rule 69L-7.501, F.A.C.;

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

5. A certified, licensed physician assistant, ~~anesthesia 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 must enter his/her Florida Department of Health license number in Field 33b.

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 a Form DFS-F5-DWC-9 using the American Medical Association’s CPT[®] procedure codes, or using the ~~unique 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 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.

7. Home Health Agencies (HHAs) shall bill on Form DFS-F5-DWC-90. ~~Federal Facilities shall bill on their usual form.~~

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.

8. Nursing Home Facilities shall bill on Form DFS-F5-DWC-90. ~~Out-of-State health care providers shall bill on the applicable medical bill form pursuant to paragraph (4)(c) of this rule.~~

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 codes and the applicable CPT[®] or HCPCS modifier code in Form Locator 44 for each service rendered.

9. Federal Facilities shall bill on their usual form ~~Dental Services.~~

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

10. Out-of-State health care providers shall bill on the applicable medical bill form pursuant to paragraph (4)(c) of this rule. ~~Pharmaceutical(s), Durable Medical Equipment and Medical Supplies.~~

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

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

II. ~~Physicians, physician assistants or ARNPs shall bill on Form DFS F5 DWC 9 and shall enter the NDC number, in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-).~~

Optionally, the unique workers' compensation code 96370 may be entered in addition to the NDC number in Field 24D.

III. 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:

I. Pharmacists shall bill on Form DFS F5-DWC-10 and shall enter the unique workers' compensation code 96371 in Field 9.

II. Physicians, physician assistants or ARNPs shall bill on Form DFS F5-DWC-9 and shall enter the unique workers' compensation code 96371 in form Field 24D.

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

e. When dispensing over the counter drug products:

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

II. Physicians, physician assistants or ARNPs shall bill on Form DFS F5-DWC-9, shall enter the NDC number in the universal 5-4-2 format, in Field 24D, with each segment separated by a dash (-). The requirement to enter the NDC number in Field 24D supersedes the instruction to enter 99070 in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.

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

d. When administering or dispensing injectable drugs:

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

II. 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 NDC number, in the universal 5-4-2 format in form Field 24D with each segment separated by a dash (-).

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

e. When dispensing durable medical equipment (DME):

~~I. Pharmacists shall bill on Form DFS F5 DWC 10 and shall enter the applicable HCPCS code in Field 21 on form revision 2/14/06 and in Field 21 on form revision 1/1/07.~~

~~II. Physicians, physician assistants or ARNPs 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, including applicable manufacturer's shipping and handling.~~

~~III. Hospitals shall bill on Form DFS F5 DWC 90 using the applicable revenue codes.~~

~~IV. Ambulatory Surgical Centers shall bill for these products on Form DFS F5 DWC 9 using applicable HCPCS codes.~~

~~V. Medical Suppliers shall bill on Form DFS F5 DWC 10 and shall enter the applicable HCPCS code in form Field 21 on form revision 2/14/06 and in Field 21 on form revision 1/1/07. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction that "the medical supplier is not required to submit codes" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.~~

~~f. 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 16 on form revision 2/14/06 and in Field 21 on form revision 1/1/07.~~

~~II. Physicians, physician assistants or ARNPs 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, including applicable manufacturer's shipping and handling. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction "under the specific HCPCS code or 99070" in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.~~

~~III. Hospitals shall bill on Form DFS F5 DWC 90 under the applicable revenue codes.~~

~~IV. Ambulatory Surgical Centers shall bill separately for these products on Form DFS F5 DWC 9 and shall enter the applicable CPT[®] code or HCPCS in Field 24D.~~

~~V. Medical Suppliers shall bill on Form DFS F5 DWC 10 and shall enter the applicable HCPCS code in Field 16 on form revision 2/14/06 and in Field 19 on form revision 1/1/07. The requirement to enter the HCPCS code when billing for medical equipment or supplies supersedes the instruction that "the medical~~

supplier is not required to submit codes” in the Florida Workers’ Compensation Health Care Provider Reimbursement Manual.

g. Pharmacists who provide Medication Therapy Management Services shall bill for these services on a Form DFS F5-DWC-9 by entering the appropriate CPT[®] code(s) 0115T, 0116T or 0117T 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.

h. 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.

11. Dental Services. 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 on their invoice or letterhead. The invoice shall not be a Form DFS F5-DWC-9, DFS F5-DWC-10, DFS F5-DWC-11, or DFS F5-DWC-90.

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.

c. When dispensing medications, dentists and oral surgeons shall submit charges on the forms specified in paragraph 11.a. and 11.b. above.

12. Pharmaceutical(s), Durable Medical Equipment and Home Medical Equipment or Supplies. Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) must accurately complete the Form DFS F5-DWC-9 and submit the form to the insurer.

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

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

II. Physicians, physician assistants, or ARNPs shall bill on Form DFS-F5-DWC-9 and shall enter the 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 must be entered in addition to the NDC number in Field 24D.

DME and medical supplies dispensed by a physician or recognized practitioner during an office visit must be billed on the DWC-9.

III. 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:

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

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

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

c. When dispensing over-the-counter drug products:

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

II. Physicians, physician assistants or ARNPs shall bill on Form DFS-F5-DWC-9, shall enter the NDC number in the 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 must be billed on the DWC-9.

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

d. When administering or dispensing injectable drugs:

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

II. 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 NDC number, in the universal 5-4-2 format in form Field 24D with each segment separated by a dash (-).

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

e. When dispensing durable medical equipment (DME):

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

III. 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.

f. 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 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.

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

IV. 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 revision 3/1/2009.

g. 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.

h. 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.

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. ~~Health care providers and other insurer authorized providers rendering services reimbursable under workers' compensation, whose billing requirements are not otherwise specified in this rule (e.g. home health agencies, independent, non-hospital based ambulance~~

~~services, air ambulance, emergency medical transportation, non-emergency transportation services, translation services, etc.) shall bill on their invoice or business letterhead. These providers shall not submit the Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90 as an invoice.~~

14. Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) must accurately complete the Form DFS-F5-DWC-9 and submit the form to the insurer.

15. Parties that are not physicians or recognized practitioners 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.

(c) Bill Completion.

1. Bills shall be legibly and accurately completed by all health care providers, regardless of location or reimbursement methodology, as set forth in this section and paragraph (4)(b) of this rule.

2. Billing elements required by the Division to be completed by a health care provider are identified in ~~specific Form DFS-F5-DWC-9-A or Form DFS-F5-DWC-9-B (completion instructions), as appropriate for the date of the revised form,~~ available at the following websites:

a. http://www.myfloridacfo.com/WC/pdf/DWC-9instrHCP_3-1-09+1-07.pdf

~~http://www.fldfs.com/wc/pdf/DWC-9instrHCP.pdf~~ when submitted by Licensed Health Care Providers;

b. http://www.myfloridacfo.com/WC/pdf/DWC-9instrASC_1-1-07.pdf

~~http://www.fldfs.com/wc/pdf/DWC-9instrASC.pdf~~ when submitted by Ambulatory Surgical Centers for dates of service up to and including 03/21/10;

c. http://www.myfloridacfo.com/WC/pdf/DWC-9instrWHPM_1-1-07.pdf

~~http://www.fldfs.com/wc/pdf/DWC-9instrWHPM.pdf~~ when submitted by Work Hardening and Pain Management Programs.

3. Billing elements required by the Division to be completed for Pharmaceutical or Medical Supplier Billing are identified in ~~specific Form DFS-F5-DWC-10 (completion instructions), as appropriate for the date of the revised form,~~ available at website: <http://www.myfloridacfo.com/WC/forms.html>

~~http://www.fldfs.com/WC/forms.html#7.~~

4. Billing elements required by the Division to be completed for Dental Billing are identified in ~~specific Form DFS-F5-DWC-11-A or Form DFS-F5-DWC-9-B (completion instructions), as appropriate for the date of the revised form,~~ available at website: <http://www.myfloridacfo.com/WC/forms.html>
<http://www.fldfs.com/WC/forms.html#7>.

5. Billing elements required by the Division to be completed for Form DFS-F5-DWC-90 Hospital Billing are identified in ~~the UB-92 Manual,~~ the UB-04 Manual, and as follows; Form DFS-F5-DWC-90-B (completion instructions) and subparagraph (4)(b)4. of this rule.

a. For Hospital billing, Form DFS-F5-DWC-90-B (UB-04) – B Completion Instructions, Rev. 1/1/2009 and subparagraph (4)(b)4. of this rule.

b. For Ambulatory Surgical Center billing, Form DFS-F5-DWC-90-C (UB-04) – C Completion Instructions, New 1/1/2009 and subparagraph (4)(b)6. of this rule.

c. For Home Health Agency billing, Form DFS-F5-DWC-90-D (UB-04) – D Completion Instructions, New 1/1/2009 and subparagraph (4)(b)7. of this rule.

d. For Nursing Home Facility billing, Form DFS-F5-DWC-90-E (UB-04) – E Completion Instructions, New 1/1/2009 and subparagraph (4)(b)8. of this rule.

6. A An insurer can require a health care provider shall submit to complete additional data elements or supporting documentation that are not required by the insurer that have been requested in writing pursuant to paragraph (5)(b) of this rule. Division on Form DFS-F5-DWC-9 or DFS-F5-DWC-11;

(5) Insurer Responsibilities.

(a) An insurer is responsible for meeting its obligations under this rule regardless of any business arrangements with any service company/TPA, submitter or any entity acting on behalf of an insurer under which medical bills claims 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 at the time a reimbursement request is received, an insurer shall notify each health care provider, in writing, of additional form completion requirements-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.

(c) At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall inform ~~in-state and~~ out-of-state health care providers of the specific reporting, billing and submission requirements contained in 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~~ Any other reporting forms may ~~not~~ be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

(e) Required data elements on each 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, 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 Claim Processing Report", as defined in the ~~date-appropriate~~ applicable 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-applicable~~ appropriate Florida Medical EDI Implementation Guide (MEIG) and subparagraphs (4)(c)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 paragraph (6)(e) of this rule.

(g) When an injured employee does not have a Social Security Number or division-assigned number, the insurer must contact the Division via information provided on the following web site:

<http://www.myfloridacfo.com/WC/organization/odqc.html>

~~<http://www.fldfs.com/WC/organization/odqc.html>~~ (under Records Management) to obtain a division-assigned number prior to submitting the medical report to the Division.

(h) An insurer, service company/TPA or any entity acting on behalf of an insurer must report to the Division the procedure code(s), number of line-items billed, diagnosis code(s), modifier code(s), NDC number and amount(s) charged, as billed by the health care provider when reporting these data to the Division. However, the insurer, service company/TPA or any entity acting on behalf of an insurer may correct the procedure code(s) or modifier code(s) or NDC number 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, service company/TPA 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.

(i) An insurer, service company/TPA 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” as defined in paragraph (1)(~~l~~~~m~~) of this rule.

(j)1. When a medical bill is submitted for reimbursement by a health care provider, the insurer, service company/TPA or entity acting on behalf of the insurer must review the medical bill to determine if any of the criteria in subparagraph (5)(j)5. of this rule are present. If a medical bill is deficient according to ~~meets any of~~ the criteria listed in subparagraph (5)(j)5. of this rule, the insurer, service company/TPA or entity acting on behalf of the insurer must either:

a. 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”; or

b. Return the medical bill to the provider within twenty-one (21) days of the “Date Insurer Received” with a written statement identifying the deficiency criteria under which the medical bill is being returned ~~within twenty one (21) days of the “Date Insurer Received”~~. 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”**.

2. If the insurer returns a medical bill to the provider pursuant to subparagraph (5)(j)5. of this rule, the written statement, which must accompany the returned bill must include all deficiency criteria upon which the return of the medical bill are based.

3. If the deficiency criteria~~on~~ upon which the return of the medical bill is based includes any of the deficiency criteria in sub-subparagraphs (5)(j)5.d.-~~g.-f.~~ of this rule, the written statement must identify the information that is illegible, incorrect, or omitted.

4. 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 subparagraph (5)(j)5. of this rule.

5. The deficiency criteria upon which a medical bill is to be reviewed by the insurer, service company/TPA or entity acting on behalf of the insurer for return to the provider pursuant to this subparagraph of paragraph (5)(j) of this rule are:

- a. Services are billed on an incorrect medical billing form; or
- b. The medical bill has been submitted to the incorrect insurer; or
- c. The medical bill has been submitted to the incorrect service company/TPA or entity acting on behalf of the insurer; or
- d. Claimant identification information required by this rule is illegible on the medical bill; or
- e. Claimant identification information required by this rule is incorrect on the medical bill; or
- f. Billing information required by this rule is illegible on the medical bill; or
- ~~g.f.~~ Billing information required by this rule is omitted or incomplete on the medical bill.

6. An insurer, 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 must be sufficiently detailed to allow verification and review by the Division.

(k) 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, 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~~)~~4~~ 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~~)(~~u~~) 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~~)(~~u~~) 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~~)(~~u~~) 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(ies). 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 as medical payment data to the Division, those payments made for ~~failed appointments~~

~~for scheduled independent medical examinations, 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)~~15.13~~, who bill on their invoice or letterhead.

(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. ~~Use the EOBR codes and code descriptors as follows up through the date for reporting production data with the Medical Data System in the Claim Record Layout Revision "D" as required in subparagraph (6)(f) of this rule:~~

- ~~a. 01 Services not authorized, as required.~~
- ~~b. 02 Services denied as not related to the compensable work injury.~~
- ~~c. 03 Services related to a denied work injury: Form DFS F2-DWC-12 on file with the Division.~~
- ~~d. 04 Services billed are listed as not covered or non-covered ("NC") in the applicable reimbursement manual.~~
- ~~e. 05 Documentation does not support the level, intensity, frequency, duration or provision of service(s) billed. (Insurer must specify to the health care provider.)~~
- ~~f. 06 Location of service(s) is not consistent with the level of service(s) billed.~~
- ~~g. 07 Reimbursement equals the amount billed.~~
- ~~h. 08 Reimbursement is based on the applicable reimbursement fee schedule.~~
- ~~i. 09 Reimbursement is based on any contract.~~
- ~~j. 10 Reimbursement is based on charges exceeding the stop loss point.~~
- ~~k. 11 Reimbursement is based on insurer re-coding. (Insurer must specify to the health care provider.)~~
- ~~l. 12 Charge(s) are included in the per diem reimbursement.~~
- ~~m. 13 Reimbursement is included in the allowance of another service. (Insurer must specify procedure to the health care provider.)~~
- ~~n. 14 Itemized statement not submitted with billing form.~~
- ~~o. 15 Invalid code. (Use only when other valid codes are present.)~~
- ~~p. 16 Documentation does not support that services rendered were medically necessary.~~

~~q. 17 Required supplemental documentation not filed with the bill. (Insurer must specify required documentation to the health care provider.)~~

~~r. 18 Duplicate Billing: Service previously paid, adjusted and paid, disallowed or denied on prior claim form or multiple billing of service(s) billed on same date of service.~~

~~s. 19 Required Form DFS F5-DWC-25 not submitted within three business days of the first treatment pursuant to Section 440.13(4)(a), F.S.~~

~~t. 20 Other: Unique EOBR code descriptor. Use of EOBR code “20” is restricted to circumstances when an above listed EOBR code does not explain the reason for payment, adjustment and payment, disallowance or denial of payment. When using EOBR code “20”, an insurer must reflect code “20” and include the specific explanation of the code on the EOBR sent to the health care provider. The insurer, service company/TPA or any entity acting on behalf of the insurer must maintain a standardized EOBR code descriptor list.~~

~~2.3.~~ When reporting production data with the Medical Data System in the Claim Record Layout-Revision “E” ~~“D”~~ 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) an insurer 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. The insurer may utilize up to three EOBR codes for each line item billed. When utilizing more than one EOBR, the insurer 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:

06 – Payment disallowed: location of service(s) is not consistent with the level of service(s) billed.

10 – Payment denied: compensability: injury or illness for which service was rendered is not compensable.

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.

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 Section 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 must 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 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 requested documentation requested in writing at the time of authorization not submitted with the medical bill. (Insurers must 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. (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 ~~processed on prior medical bill.~~

61 – Payment disallowed: billing error: duplicate bill. (Shall not be transmitted electronically to the Division.) ~~same service billed multiple times on same date of service.~~

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

63 – Payment disallowed: billing error: service billed is integral component of another procedure code.

(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, 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.

69 – Payment disallowed: billing error: Correct Coding Initiative guidelines indicate this code is a comprehensive component of code XXXXX billed 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 requested 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.

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

~~82 – Payment adjusted: payment modified pursuant to carrier charge analysis.~~

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

84 – Payment adjusted: co-payment applied pursuant to 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.

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).

94 – Paid: Out-of-State Provider: payment made pursuant to the Out-of-State Provider section of the applicable Florida reimbursement manual.

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 Section 440.13(7), F.S.

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

(p) An insurer, service company/TPA, submitter or any entity acting on behalf of the insurer shall make available to the Division ~~and to the Agency~~, 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 paragraph (o) of this section, and shall include the insurer name, Division issued

insurer number and corresponding specific insurer mailing address contact information. 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 paragraph (o) that includes a code descriptor requiring the insurer to provide additional specification. 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 Section 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 Section 440.13(7)(a), F.S.

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

(s) 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), 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 Section~~ 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 Section~~ 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 (~~i.e. a single bill equals a single datum transmission~~).

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

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

(b) 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).

(c) The Division will notify the insurer on the “Medical ~~Bill Claim~~ Processing Report” of the corrections necessary for rejected medical reports to be electronically re-filed with the Division. An insurer shall correct and re-file all rejected medical ~~claim~~ reports to meet the filing requirements of paragraph (5)(e) of this rule.

(d) Submitters who experience a catastrophic event resulting in the insurer’s failure to meet the reporting requirements in paragraph (5)(e) 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 must be obtained from the Division's Office 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.

(e) When filing any medical report replacement that corrects a rejected medical report bill or replaces a previously accepted medical report bill, the submitter shall use the same control number as the original submission. The replacement report submission shall contain all information necessary to process the medical report bill including all services and charges from the medical bill claim as billed by the health care provider and all payments made by the insurer to the health care provider. Additionally, an insurer or entity acting on behalf of an insurer shall follow the EDI medical bill replacement methodology specified in the 2010 Florida Medical EDI Implementation Guide (MEIG), using Report Reason Code "03" (See Appendix C), after being notified by the Division that data previously accepted has been deemed inaccurate and responding to a written request from the Division to review, correct, and re-submit accurate data. Each Division written request shall have a specified timeline to which the insurer or entity acting on behalf of an insurer shall adhere. Information contained on the original submission is deemed independent and is not considered as a supplement to information contained in the replacement submission.

(f) Each ~~Additionally, an~~ insurer shall be responsible for accurately completing the electronic record-layout programming requirements for the reporting of the Form DFS-F5-DWC-9 ~~Claim Detail Record Layout – Revision "E" "D"~~, Form DFS-F5-DWC-10 ~~Claim Detail Record Layout – Revision "E" "D"~~, Form DFS-F5-DWC-11 ~~Claim Detail Record Layout – Revision "E" "D"~~ and Form DFS-F5-DWC-90 ~~Claim Detail Record Layout – Revision "E" "D"~~ in accordance with the Florida Medical EDI Implementation Guide (MEIG), 2010~~7~~, to the Division in accordance with the phase-in schedule as denoted below in subparagraphs 1., 2., and 3. of this section. The electronic record layout for Form DFS-F5-DWC-90 in the MEIG 2010 adds the new fields for Provider Facility National Provider Identification (NPI) number, Florida Agency for Health Care Administration facility license number for Ambulatory Surgical Centers, Home Health Care Agencies, and Nursing Home Facilities, procedure, service or supply code modifier 2 as billed by the provider, procedure, service or supply code modifier 3 as billed by the provider.

procedure, service or supply code modifier 4 as billed by the provider, procedure, service or supply code as paid by the insurer, procedure, service or supply code modifier 1 as paid by the insurer, procedure, service or supply code modifier 2 as paid by the insurer, procedure, service or supply code modifier 3 as paid by the insurer, procedure, service or supply code modifier 4 as paid by the insurer, and the line item amount paid by the insurer. The electronic record layout for Form DFS F5 DWC 9 in the MEIG, 2007, adds the new fields for gender, date of birth, up to three new modifiers and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS F5 DWC 10 in the MEIG, 2007, adds the new fields for gender, date of birth, pharmacist's Florida Department of Health license number, and, medical supply and equipment HCPCS code(s), quantity, purchase or rental date, usual charge, amount paid, prescriber's license number and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS F5 DWC 11 in the MEIG, 2007, adds the new fields for gender, date of birth and a maximum of three EOBR codes per line item from the revised code set. The electronic record layout for Form DFS F5 DWC 90 in the MEIG, 2007, adds the new form locators for gender, date of birth, designation of surgery as scheduled or unscheduled, implant amount, up to three External Cause of Injury codes, four additional ICD 9 diagnostic codes, four other procedure codes, operating physician's Florida DOH license number and a maximum of three EOBR codes per line item from the revised code set. The conversion implementation schedule is as follows:

1. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “D” “C”), between ~~04/01/2007~~ ~~4/2/05~~ and ~~06/15/2007~~ ~~2/24/06~~ shall begin testing on ~~03/01/2010~~ ~~4/2/07~~ and shall complete the testing process with the new Revision “E” “D” record layouts no later than ~~04/12/2010~~ ~~5/4/07~~.

2. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “D” “C”), between ~~06/16/2007~~ ~~2/25/06~~ and ~~08/07/2007~~ ~~3/31/06~~ shall begin testing on ~~04/13/2010~~ ~~5/15/07~~ and shall complete the testing process with the new Revision “E” “D” record layouts no later than ~~05/25/2010~~ ~~6/26/07~~.

3. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “D” “C”), between ~~08/08/2007~~ ~~4/4/06~~ and the effective date of this rule shall

begin testing on ~~05/26/2010~~~~6/27/07~~ and shall complete the testing process with the new Revision "E" ~~"D"~~ record layouts no later than ~~07/07/2010~~~~8/8/07~~.

4. The Division will, resources permitting, allow submitters that volunteer to complete the test transmission processes earlier than the schedule denoted above. Each voluntary submitter shall have six weeks to complete test transmission to production transmission processes, for all electronic form equivalents, that comply with requirements set forth in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 20107.

(g) All submitters shall be in production with the new Revision "E" ~~"D"~~ record layouts on ~~07/08/2010~~~~8/9/07~~. ~~Optionally, after successful completion of the testing process and continuing up to and including 8/8/07, submitters may elect to submit all required medical reports as required in the new Revision "D" record layouts, as required in the current Revision "C" record layouts, or, as required in the Revision "C" record layouts for billings on the current medical claim forms and as required in the Revision "D" record layouts for billings on the new medical claim forms.~~

(h) Submitters who do not accurately complete and maintain electronic record-layout programming requirements of this rule shall not submit medical reports electronically until the submitter has been approved for reporting production data with the Medical Data System as necessary to meet the filing requirements of paragraph (5)(e) of this rule.

(7) Insurer Administrative Penalties and Administrative Fines for Untimely Health Care Provider-Payment or Disposition of Medical Bills.

(a) The Department shall impose insurer administrative penalties for failure to comply with the payment, adjustment, disallowance or denial requirements pursuant to Section 440.20(6)(b), F.S. Timely performance standards for timely payments, adjustments and payments, disallowances or denials, reported on Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90, shall be calculated and applied on a monthly basis for each separate form category that was received within a specific calendar month. Such insurer penalties shall be determined according to the penalty schedule in paragraph (7)(b) of this rule.

(b) Pursuant to Section 440.185(9), F.S., the Department shall impose insurer administrative fines for failure to comply with the submission, filing or reporting requirements of this rule. Insurer administrative fines shall be applied as follows:

1. Calculated on a monthly basis for each separate form category (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90) received and accepted by the Division within a specific calendar month; and

2. Insurers are required to report all medical reports timely pursuant to paragraph (5)(e) of this rule. Insurers that fail to submit a minimum of 95% of all medical reports timely are subject to an administrative fine. Each untimely filed medical report which falls below the 95% requirement is subject to the following penalty schedule:

- a. 1 – 30 calendar days late \$5.00;
- b. 31 – 60 calendar days late \$10.00;
- c. 61 – 90 calendar days late \$25.00;
- d. 91 or greater calendar days late \$100.00.

3. Each medical report that does not pass the electronic reporting edits shall be rejected by the Division and considered not filed pursuant to paragraph (5)(e) of this rule. If the medical report remains rejected and not corrected, resubmitted and accepted by the Division for greater than 90 days, an administrative fine shall be assessed in the amount of \$100.00 for each such medical report. Rejected and not resubmitted medical reports will not be included in the 95% timely reporting requirement.

4. Untimely filed medical reports for a given month will be excluded from the administrative fine set forth in subparagraph (7)(b)3. above as falling within the performance standard between 100% and 95% in the following order:

- a. Medical Reports filed 1 – 30 calendar days late; then
- b. Medical Reports filed 31 – 60 calendar days late; then
- c. Medical Reports filed 61 – 90 calendar days late; then
- d. Medical Reports filed 91+ calendar days late.

Rulemaking Specific Authority 440.13(4), 440.15(3)(b), (d), 440.185(5), 440.525(2), 440.591, 440.593(5) FS. Law Implemented 440.09, 440.13(2)(a), (3), (4), (6), (11), (12), (14), (16), 440.15(3)(b), (d), 440.185(5), (9), 440.20(6),

440.525(2), 440.593 FS. History–New 1-23-95, Formerly 38F-7.602, 4L-7.602, Amended 7-4-04, 10-20-05, 6-25-06,
3-8-07,_____.