

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

(c) "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 claim to an insurer, service company/third party administrator (TPA) or any entity acting on behalf of the insurer, to receive reimbursement for medical services provided to an injured employee.

~~(e)~~(d) "Catastrophic Event" means the occurrence of an event outside the control of an insurer, ~~or~~ submitter, service company/third party administrator (TPA) or any entity acting on behalf of the insurer, such as a natural disaster, an act of terrorism (including but not limited to cyber terrorism) or a telecommunications failure, in which recovery time will prevent an insurer, ~~or~~ submitter, service company/TPA or any entity acting on behalf of the insurer from meeting the filing and reporting requirements of Chapter 440, F.S., and this rule.

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

~~(g)~~(f) “Charge Master” means a comprehensive coded list developed by a hospital or an ambulatory surgical center representing its usual charges for specific services and supplies.

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

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

~~(j)~~(f) “Date Insurer Paid” means the date the insurer, service company/~~third party administrator TPA~~, or submitter or any entity acting on behalf of the insurer mails, transfers or electronically transmits payment to the health care provider.

~~(k)~~(j) “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 delivered to, and manually or electronically date stamped by, the insurer, service company/~~third party administrator TPA~~, or submitter or any entity acting on behalf of the insurer from a provider.

~~(l)~~(k) “Deny” means to determine that no payment is to be made for a specific procedure code or other service reported by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer on a bill.

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

~~(n)(m)~~ “Disallow” means to determine that no payment is to be made for a specific procedure code or other service reported by a health care provider to an insurer, service company/TPA or any entity acting on behalf of the insurer for reimbursement, based on identification of a billing error, inappropriate utilization or over utilization, use of an incorrect billing form, only one line-item billed and the bill has an invalid code, or required information is inaccurate, missing or illegible.

~~(o)(n)~~ “Electronic Filing” means the computer exchange of medical data from a submitter to the division in the standardized format defined in the Florida Workers’ Compensation Medical EDI Implementation Guide (MEIG), 2005 ~~2004~~.

~~(p)(e)~~ “Electronic Form Equivalent” means the format, provided in the Florida Workers’ Compensation Medical EDI Implementation Guide (MEIG), 2005 ~~2004~~, 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.

~~(q)(p)~~ “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.

~~(r)~~ “Entity” means any party, involved in the provision of or the payment for medical services, care or treatment rendered to the injured employee, excluding the insurer, service company/TPA or health care provider as identified in this section.

~~(s)(q)~~ “Explanation of Bill Review” (EOBR) means the codes and written explanation of an insurer’s reimbursement decision sent to the health care provider as notice of payment, denial, disallowance or adjustment.

~~(t)(t)~~ “Florida Workers’ Compensation Medical EDI Implementation Guide (MEIG), ~~2005~~ 2004” 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.

~~(u)(s)~~ “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.

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

~~(w)(u)~~ “Hospital” is defined in ~~means any health care institution licensed under Section Chapter 395.002(13), F.S.~~

~~(x)(v)~~ “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.

~~(y)(w)~~ “Insurer” is defined in Section 440.02(38), F.S.

~~(z)(x)~~ “Insurer Code Number” means the number the division assigns to each individual insurer, self-insured employer or self-insured fund.

~~(aa)(y)~~ “Itemized Statement” means a detailed listing of ~~hospital provided~~ services and supplies provided to an injured employee, including the quantity and charges for each service or supply.

~~(z)~~ “~~Medical Summary Report~~” ~~means an Excel spreadsheet format that denotes an insurer, service company or third party administrator payment, adjustment and payment, disallowance or denial information.~~

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

~~(cc)~~(bb) “NDC number” means the National Drug Code (NDC) number, assigned under Section 510 of the Federal Food, Drug, and Cosmetic Act, which ~~that~~ identifies the drug product labeler/vendor, product, and trade package size.

~~(cc)~~ “Paper Form Filed with the Division” means the date a paper document is accurately completed, postmarked and mailed pre-paid to the Department of Financial Services as a required filing under this rule.

(dd) “Physician” is defined in Section 440.13(1)(q), F.S.

(ee) “Physician’s Current Procedural Terminology (CPT®)” (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.

(ff) “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.

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

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

(ii) "Service Company/Third Party Administrator (TPA) Code Number" means the number the division assigns to each third party administrator, claims administrator or servicing company.

(jj) "Submitter" means an insurer, service company/~~or third party administrator~~ (TPA), entity or any other party entity acting as an agent or vendor on behalf of an insurer, service company/~~or TPA~~ third party administrator, or entity to fulfill any insurer responsibility to electronically transmit required medical data to the division.

(kk) "UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, ~~April-May 2005~~ 2004" (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 /~~UB-92~~).

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

(a) Form DFS-F5-DWC-9 (CMS -1500 Health Insurance Claim Form, Rev. 12/90);~~;~~ Completion Instructions for Form DFS-F5-DWC-9 – A (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; Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form), Rev. 5/26/2005; ~~3/2004;~~ Completion Instructions for Form DFS-F5-DWC-10 – A, Rev. 5-26-05; Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2002);~~;~~ Completion Instructions for Form DFS-F5-DWC-11– A, Rev. May 26, 2005; Form DFS-F5-DWC-25 (Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form), Rev. 05/26/2005-03/2004);~~;~~ Completion/Submission Instructions for Form DFS-F5-DWC-25, Rev. May 26, 2005; and Form DFS-F5-DWC-90 (UB-92 HCFA-

1450, Hospital Uniform Bill, Rev./UB-92, Effective 1992) and completion instructions for these forms are hereby incorporated by reference into this rule.

1. A copy of the Form DFS-F5-DWC-9 can be obtained from the CMS web site: <http://www.cms.hhs.gov/forms/>. Completion instructions can be obtained from the DFS/DWC web site: <http://www.fldfs.com/WC/forms.html#7>.

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

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

5. A copy of the Form DFS-F5-DWC-90 can be obtained from the CMS web site: <http://www.cms.hhs.gov/forms/>. Completion instructions can be obtained from the UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee (Rev. April 2005) and sub-subparagraph (4)(e)5. of this rule DFS/DWC web site: <http://www.fldfs.com/WC/forms.html#7>.

(b) 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 on the Form DFS-F5-DWC-10. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be submitted as an alternate form.

(3) Materials Adopted for 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. ~~June-May 2005~~ 2004). A copy of this manual can be obtained from the Florida Hospital Association by calling (407) 841-6230.

(b) The Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), ~~2005~~ 2004. Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), ~~2005~~ 2004 can be obtained from the DFS/DWC web site: [http://www.fldfs.com/WC/pdf/MedDataElecFilingManual2005\\_5-26-05.pdf](http://www.fldfs.com/WC/pdf/MedDataElecFilingManual2005_5-26-05.pdf).

(c) The American Medical Association "Healthcare Common Procedure Coding System, Medicare's National Level II Codes (HCPCS), ~~Centers for Medicare and Medicaid Services~~, as adopted in Rule 69L-7.020, F.A.C. Copyright 2003, American Medical Association.

(d) The Physicians' Current Procedural Terminology (CPT®), as adopted in Rule 69L-7.020, F.A.C. Copyright 2003, American Medical Association.

(e) The Current Dental Terminology (CDT-4), as adopted in Rule 69L-7.020, F.A.C., ~~Fourth Edition~~ Copyright 2003, American Dental Association.

(f) The 2005 ICD-9-CM Professional for Hospitals, Volumes 1, 2, & 3, International Classification of Diseases, 9th Revision, Clinical Modification, Sixth Edition, Copyright 2004 2003, Ingenix-American Medical Association.

(g) The Physician ICD-9-CM 2005, Volumes 1 & 2, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2004, American Medical Association.

~~(h)(g)~~ The American Medical Association's Guide to the Evaluation of Permanent Impairment, 3rd Edition, (AMA Guide) (Copyright 1988 by the American Medical Association), as adopted incorporated in Rule Chapter 69L-7.604, F.A.C.

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

~~(j)(i)~~ The Florida Impairment Rating Guide, as adopted incorporated in Rule Chapter 69L-7.604, F.A.C.

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

(4) Health Care Provider Responsibilities.

(a) All 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.

(b) Each health care provider is responsible for submitting any additional form completion information and supporting documentation requested by the insurer at the time of authorization, or at the time a reimbursement request is received.

(c) ~~(a)~~ Insurers and providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of the injured employee's medical treatment/status. Any other reporting forms may not be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

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

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

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

3. 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, shall enter his/her Florida Department of Health license number in Field 33 on the Form DFS-F5-DWC-9:

a. any ~~When a~~ licensed physician; or

b. any non-physician health care provider, including a physician assistant or an ARNP (not providing an anesthesia-related service); ~~or renders direct billable services for which reimbursement is sought from an insurer, he/she shall enter his/her Florida Department of Health license number in Field 33 on the Form DFS-F5-DWC-9, regardless of the employment arrangement under which the services were rendered or the party submitting the bill.~~

c. any licensed non-physician health care providers whose licensure permits independent billing.

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

a. Inpatient billing – Hospitals shall:

I. in addition to filing a Form DFS-F5-DWC-90, attach an itemized statement with charges based on the facility's Charge Master, ~~and~~.

II. enter the ZIP Code applicable to the hospital's physical location in Form Locator 84 – 'Remarks', on the DFS-F5-DWC-90. The ZIP Code must be the first entry within the 'Remarks' area when multiple entries are made in Form Locator 84; and

b. Outpatient billing: – Hospitals shall:

I. ~~Hospitals shall~~ in addition to filing a Form DFS-F5-DWC-90, enter the CPT, HCPCS, or unique workers' compensation code (provided in the Florida Workers' Compensation Health Care Provider Reimbursement Manual adopted in Rule 69L-

7.020, F.A.C., 2004 Edition) in Form Locator 44 on the Form DFS-F5-DWC-90, to bill outpatient radiology, clinical laboratory and physical, occupational or speech therapy charges treatments, and.

II. enter a surgical CPT code in Form Locator 44 when billing outpatient surgery or surgical services; and

~~III-H. Hospitals shall~~ enter the date of service on Form DFS-F5-DWC-90, in Form Locator 45, for outpatient billing; and.

~~IV-H. Hospitals shall bill supplies by filing a Form DFS-F5-DWC-90 and attaching~~ an itemized statement with charges based on the a facility's Charge Master if there is no line item detail shown on the Form DFS-F5-DWC-90; and.

V. enter the ZIP Code applicable to the hospital's physical location in Form Locator 84 – 'Remarks' on the DFS-F5-DWC-90. The ZIP Code must be the first entry within the 'Remarks' area when multiple entries are made in Form Locator 84.

5. Certified, Licensed physician assistants, anesthesia assistants and certified registered first-nurse first assistants who provide surgical assistance on procedures with codes permitting an assistant surgeon-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 their Florida Department of Health license number in Field 33.

6. Ambulatory Surgical Centers (ASCs) shall bill on a Form DFS-F5-DWC-9.

7. Federal Facilities shall bill on their usual form.

8. 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.

9. Pharmaceutical and Medical Supplies.

a. Pharmacists and medical suppliers shall bill on a Form DFS-F5-DWC-10 or on an insurer pre-approved alternate form. Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 shall not be submitted as an alternate form.

b. Pharmacists shall complete Field 9, on a Form DFS-F5-DWC-10, by entering the unique workers' compensation code 96371 ~~word "COMPOUND"~~ when medicinal drugs are compounded and the formulation prescribed is not commercially available.

c. Dispensing physicians, physician assistants or ARNPs shall bill on a Form DFS-F5-DWC-9, when supplying commercially available medicinal drugs (commonly known as legend or prescription drugs) and shall enter the NDC number in Field 24D. Optionally, the unique workers' compensation code 96370 may be entered in addition to the NDC code, in Field 24D.

d. When administering or supplying injectable drugs, the physician, physician assistant or ARNP shall bill on a Form DFS-F5-DWC-9 and enter the appropriate HCPCS "J" code in Field 24D.

~~e~~-d. Dispensing physicians shall complete Field 24D, on a Form DFS-F5-DWC-9, by entering the unique workers' compensation code 96371 when medicinal drugs are compounded and the formulation prescribed is not commercially available.

~~f~~-e. Dispensing physicians, physician assistants or ARNPs shall bill by entering code 99070 in Field 24D, on a Form DFS-F5-DWC-9, when supplying over-the-counter

drugs and shall submit an invoice indicating the name, dosage, package size and cost of the drug(s).

g.f. Physicians and other licensed health care providers providing medical supplies shall bill on a Form DFS-F5-DWC-9 and attach ~~an invoice~~ documentation indicating the actual cost of the supply, including applicable manufacturer's shipping and handling ~~and taxes, when applicable.~~

10. 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.

11. Health care providers receiving reimbursement under any payment plan (pre-payment, prospective pay, capitation, etc.) must accurately complete the Form DFS-F5-DWC-9 on the date of service. A Form DFS-F5-DWC-9 must be submitted to the insurer within 30 calendar days following the date of each service.

~~12.10.~~ Health care providers and other insurer authorized providers rendering health care services reimbursable under workers' compensation, whose billing requirements are not otherwise specified in this rule (e.g. home health agencies, independent ambulance services, transportation services, etc.), shall bill on their invoice or business letterhead. These providers shall not submit the Forms DFS-F5-DWC-9, DFS-F5-DWC-11 or DFS-F5-DWC-90 as an invoice.

~~(e)(e)~~ 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 paragraph.

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 (completion instructions), available at the following websites as follows:

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

b. <http://www.fldfs.com/wc/pdf/DWC-9instrASC.pdf> when submitted by Ambulatory Surgical Centers;

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

~~Physician and Non-Physician/Certified Provider Billing – Form DFS-F5-DWC-9.~~

~~(I) Field 1a Injured employee's Social Security Number or division-assigned number (obtained from the Insurer).~~

~~(II) Field 2 Injured employee's name: Last, First, Middle initial, if applicable.~~

~~(III) Field 14 Date of current accident, illness or injury.~~

~~(IV) Field 16 Dates injured employee is unable to work, as applicable.~~

~~(V) Field 21(1) Diagnosis of primary injury or illness (Include decimal in ICD-9 code, as applicable).~~

~~(VI) Field 21 (2-4) Additional diagnoses (Include decimal in ICD-9 code, as applicable).~~

~~(VII) Field 24A Date(s) of service: 'From' and 'To' date. Multiple dates of service are billable on a single line only if the dates are consecutive. If there is a single date of service, enter the same date in both 'From' and 'To' fields.~~

~~(VIII) Field 24B Place of service (as listed in the CPT manual).~~

~~(IX) Field 24D Procedure, service or supply code (CPT, CDT-4, HCPCS, NDC or unique workers' compensation code plus modifier, as required for reimbursement).~~

~~(X) Field 24E Diagnosis code reference numbers: '1', '2', '3', '4' refer to corresponding diagnoses listed in Field 21 (1, 2, 3, 4).~~

~~(XI) Field 24F Total dollar charges for units billed per line.~~

~~(XII) Field 24G Number of days, hours, units, or quantity of drug or supply must be entered in whole numbers. Total length of anesthesia service time must be entered in minutes.~~

~~(XIII) Field 25 Federal tax identification number.~~

~~(XIV) Field 32 ZIP code where services were rendered.~~

~~(XV) Field 33 (PIN#) License number of the health care provider rendering direct billable service(s): Providers shall enter their Florida Department of Health provider license, out of state license, or other facility number as assigned by the professional regulatory board, licensing authority or state regulatory agency.~~

~~(A) Work Hardening/Pain Programs enter "WC" for required alpha characters (i.e. WC#####).~~

~~(B) Ambulatory Surgical Centers enter "ASC" for required alpha characters (i.e. ASC### or ASC#####).~~

~~(C) Independent Laboratories enter "IL" for required alpha characters (i.e. IL8000#####, IL80000##### or IL800000###).~~

~~(D) Advanced Registered Nurse Practitioners enter "ARNP" for required alpha characters (i.e. ARNP##### or ARNP##### or ARNP#####).~~

~~(E) Radiology or Other Facilities (providing only the technical component) enter “XX” for required alpha characters and 99999999999 for required numeric characters (i.e. XX99999999999).~~

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) available at website: <http://www.fldfs.com/wc/pdf/DWC-10.pdf>.

~~b. Pharmaceutical/Medical Supplier Billing — Form DFS-F5-DWC-10.~~

~~(I) Form DFS-F5-DWC-10 Section 1 — Fields required to be completed by Pharmacy and Medical Supply providers:~~

~~(A) Field 1 Injured employee’s name: Last, First, Middle Initial, if applicable.~~

~~(B) Field 2 Injured employee’s Social Security Number or division-assigned number (obtained from the insurer).~~

~~(C) Field 3 Date of current accident, injury or illness in MM/DD/CCYY format.~~

~~(II) Form DFS-F5-DWC-10 Section 2 — Fields required to be completed by pharmacy providers only:~~

~~(A) Field 6 Medication/drug name and strength.~~

~~(B) Field 7 Number of tablets, capsules, suppositories, milliliters of liquid, grams of ointment or units of injectable medication.~~

~~(C) Field 8 Estimated number of days that medication will last according to prescription dosage and administration instructions.~~

~~(D) Field 9 National Drug Code number: manufacturer number, item number, package number; enter “COMPOUND” if a compounded drug is dispensed.~~

~~(E) Field 10 Pharmacy’s internal number assigned to the prescription.~~

~~(F) Field 15 Pharmacy's usual charges for the drug. When field 13 is coded, enter the usual charges for the generic equivalent.~~

~~(III) Form DFS-F5-DWC-10 Section 3—Fields required to be completed by Medical Supplier or Pharmacy providing medical supplies:~~

~~(A) Field 16 Description or name of item supplied: quantity and size, when applicable.~~

~~(B) Field 17 Prescriber's license number assigned by the professional regulatory board or licensing authority.~~

~~(C) Field 18 Purchase date in MM/DD/CCYY format.~~

~~(D) Field 19 Medical supplier's usual charge for item(s) supplied.~~

~~(IV) Form DFS-F5-DWC-10 Section 4—Fields required to be completed by Pharmacy and Medical Supply providers:~~

~~(A) Field 20 Total dollar charges appearing on this statement.~~

~~(B) Field 22 Date pharmacy or medical supplier submits statement to insurer for payment in MM/DD/CCYY format.~~

~~(C) Field 23 Pharmacist's license number assigned by professional regulatory board or licensing authority.~~

~~(D) Field 24 Pharmacy's or medical supplier's federal employer identification number.~~

4. Billing elements required by the division to be completed for Dental Billing are identified in specific Form DFS-F5-DWC-11– A (completion instructions), available at website: <http://www.fldfs.com/WC/forms.html#7>.

~~c. Dental Billing—Form DFS-F5-DWC-11.~~

~~(I) Field 20 Injured employee's name: Last, First, Middle initial, if applicable.~~

~~(II) Field 8 Injured employee's Social Security Number or Division-assigned number (obtained from the insurer).~~

~~(III) Field 51 Federal tax identification number.~~

~~(IV) Field 55 Dentist's Florida Department of Health license number (i.e. DN#### or DN#####).~~

~~(V) Field 38 Place of treatment (check appropriate box):~~

~~(A) Office.~~

~~(B) Hospital.~~

~~(C) Extended Care Facility.~~

~~(D) Other.~~

~~(VI) Field 56 Address where services were rendered, including ZIP code.~~

~~(VII) Field 46 Date of current accident, injury or illness.~~

~~(VIII) Field 24 Date treatment/service performed.~~

~~(IX) Field 29 'Procedure Code' Procedure, service or supply code (CPT, GDT-4 or HCPCS 'D' code).~~

~~(X) Field 31 Total dollar charges per line item.~~

5. Billing elements required by the division to be completed for Hospital Billing are identified in the UB-92 Manual.

~~(I) Locator 1 Hospital's location ZIP code.~~

~~(II) Locator 4 Type of bill.~~

~~(III) Locator 5 Federal tax identification number.~~

~~(IV) Locator 6 Date statement covers period from/through.~~

- ~~(V) Locator 12 Injured employee's name: Last, First, Middle initial, if applicable.~~
- ~~(VI) Locator 17 Admission date.~~
- ~~(VII) Locator 18 Admission hour.~~
- ~~(VIII) Locator 19 Type of Admission/Visit.~~
- ~~(IX) Locator 21 Discharge hour, if applicable.~~
- ~~(X) Locator 32 Date of accident, injury or illness.~~
- ~~(XI) Insurer name, address and location ZIP code.~~
- ~~(XII) Locator 42 Revenue code.~~
- ~~(XIII) Locator 44 CPT, HCPCS, or unique workers' compensation code and modifier(s), as required for reimbursement.~~
- ~~(XIV) Locator 45 Date of Service, required for outpatient billing.~~
- ~~(XV) Locator 46 Number of service units.~~
- ~~(XVI) Locator 47 Total dollar charges billed by revenue code.~~
- ~~(XVII) Locator 60A Injured employee's Social Security Number or Division-assigned number (obtained from the insurer).~~
- ~~(XVIII) Locator 67 Principal diagnosis code (ICD-9 code).~~
- ~~(XIX) Locators 68-75 Other diagnosis codes (ICD-9 codes), as applicable.~~
- ~~(XX) Locator 80 Principal procedure code, as applicable.~~
- ~~(XXI) Locator 81 (A, B, C, D, E) Other procedure codes, as applicable.~~
- ~~(XXII) Locator 82 Attending physician's Florida Department of Health license number.~~

~~63~~. An insurer can require a health care provider to complete additional data elements that are not required by the division on Forms DFS-F5-DWC-9 or DFS-F5-DWC-11.

~~(f)(d)~~ Provider Bill Submission/Filing and Reporting Requirements.

1. All medical claim form(s) or bill(s) related to services rendered for a compensable injury shall be 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.

2. Medical claim form(s) or 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.

3. Medical claim form(s) or bill(s) shall be filed with an insurer, service company/TPA or any entity acting on behalf of the insurer, according to the following requirements:

a. Health Care Providers (excluding hospitals):

Within 30 calendar days of initial or additional service or treatment and accompanied by required documentation that supports medical necessity. This requirement includes Pharmacies, Medical Suppliers, and Ambulatory Surgical Centers.

b. Hospitals:

(I) Within 30 calendar days following emergency room or initial outpatient treatment.

(II) Within 30 calendar days of an injured employee's discharge from an in-patient hospital stay or follow-up outpatient treatment.

(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 claims are adjusted, processed or submitted to the division.

(b) At the time of authorization for medical service(s) or at the time a reimbursement request is received, an insurer shall notify each a health care provider of additional form completion requirements or supporting documentation that are necessary for reimbursement ~~determinations in excess of the requirements set forth in this rule.~~

(c) At the time of authorization for medical service(s), an insurer shall inform an out-of-state health care provider of the specific reporting, billing and submission requirements of this rule.

(d) Insurers and providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of an injured employee's medical treatment /status, ~~and~~ 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 Forms 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 insurer, service company/TPA or any entity acting on behalf of the insurer, payment, adjustment and payment, disallowance or denial. This 45-calendar day requirement includes initial submission and correction and re-submission of all errors identified in the "Medical Claim Processing Report", as

defined in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), ~~2005~~ 2004.

(f) An insurer shall be responsible for accurately completing required data filed with the division, as of the effective date of this rule, pursuant to the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), ~~2005~~ 2004 and subparagraphs ~~(4)(e)~~2.-5. 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 website: <http://www.fldfs.com/WC/organization/odqc.html> (under Records Management) to obtain a division-assigned number prior to submitting the report to the division.

(h) An insurer ~~shall attach an accurately completed cover sheet, as required in subparagraph (6)(f)4. of this rule, to each paper form batch submitted to the division. or service company/TPA~~ (i) An insurer must report to the division the procedure, diagnosis or modifier code(s) or amount(s) charged, as billed by the health care provider.

~~(i)(j)~~ An insurer, service company/TPA or any entity acting on behalf of the insurer shall manually or electronically date stamp Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or a submitter shall date stamp the electronic form equivalent with the date insurer received.

~~(i)(k)~~ An insurer, service company/TPA or any entity acting on behalf of the insurer shall return any bills to the provider, with a written explanation, when:

1. services are billed on an incorrect billing form; or

2. an invalid code is used and is the only line-item billed; or

3. required information is illegible, inaccurate, or omitted-not provided.

~~(k)(4)~~ An insurer shall pay, adjust and pay, disallow or deny billed charges within 45 calendar days from the date insurer received, pursuant to Section 440.20(2)(b), F.S.

~~(l)(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 ~~actual~~ dollar amount paid by the insurer to the health care provider or reimbursed to the employee for healthcare service(s) or supply(ies). When reporting ~~On~~ disallowed or denied charges, the dollar amount paid shall ~~should~~ be reported as \$0.00.

(m) An insurer shall not report as medical payment data, those payments made for failed appointments for scheduled independent medical examinations.

(n) An ~~insurer~~ submitter insurer, filing electronically, shall submit to the division the Explanation of Bill Review (EOBR) code(s), relating to the adjudication of each line item billed and:

1. Maintain the EOBR in a format that can be legibly reproduced, and

2. Use the EOBR codes and descriptors as follows:

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 or duration of service(s) billed. (Insurer must specify to the 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 ~~the contracted amount~~.
- 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 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 provider.)
- n. 14 Hospital itemized statement not submitted with billing form.
- o. 15 Invalid procedure code. (Use when other valid procedure 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 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 ~~form~~ 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 description. Use of EOBR code “20” is restricted to circumstances when an above-listed EOBR code does not explain the reason for adjustment, 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 provider. The insurer must~~and~~ maintain a standardized EOBR code description list.

(o) 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 ~~or~~ standardized EOBR code “20” description list.

(p) An insurer, service company/TPA or any entity acting on behalf of the insurer to pay, adjust and pay, disallow or deny a filed bill shall submit to the health care provider an Explanation of Bill Review, utilizing the EOBR codes and descriptions, as listed in sub-paragraph (n) of this section~~above~~, and shall include ~~including~~ the insurer name and specific insurer contact information.

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

(6) Insurer Electronic Medical Report (~~Electronic Format, Paper format, or Excel spreadsheet format~~) Filing ~~t~~To ~~t~~The Division.

(a) Effective March 16, 2005, all required medical reports shall be electronically filed with the division by all insurers. ~~In meeting this requirement an insurer shall comply with the following implementation schedule, as applicable:~~

1. 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 “C” and the Form DFS-F5-DWC-10 Claim Detail Record Layout – Revision “C”, Form DFS-F5-DWC-11 Claim Detail Record Layout – Revision “C” and Form DFS-F5-DWC-90 Claim Detail Record Layout – Revision “C” in accordance with the Florida Workers’ Compensation Medical Implementation Guide (MEIG), 2005, to the division in accordance with the phase-in schedule as denoted below in sub-paragraphs a., b., and c. of this section. The electronic record layout for Form DFS-F5-DWC-9 in the MEIG, 2005, adds the new field 30A for submission of the pre-payment/employee payment indicator and the new field 31A for submission of the duplicate override indicator and adds the new field 18B for submission of the National Drug Code (NDC) number. The electronic record layout for Form DFS-F5-DWC-10 in the MEIG, 2005, adds the new field 24A for submission of the pre-payment/employee payment indicator and the new field 25A for the submission of the duplicate override indicator and adds a claim detail record layout, which includes form fields 7, 8, 9, 10, 11, 12, 13, 14 and 15 for Section 2 – Prescription Drugs. The electronic record layout for Form DFS-F5-DWC-11 in the MEIG, 2005, adds the new field 27A for submission of the pre-payment/employee payment indicator and the new field 28A for submission of the duplicate override indicator. The electronic record layout for Form DFS-F5-DWC-90 in the MEIG, 2005, adds the new field 40A for submission of

the pre-payment/employee payment indicator and the new field 41A for submission of the duplicate override indicator. The conversion implementation schedule is as follows:

a. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “B”), between August 2, 2004 and November 9, 2004 shall begin testing on December 5, 2005 and shall be in production with the new record layouts no later than January 13, 2006.

b. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “B”), between November 10, 2004 and February 28, 2005 shall begin testing on January 16, 2006 and shall be in production with the new record layouts no later than February 24, 2006.

c. Submitters who have been approved for reporting production data with the Medical Data System (Record Layout – Revision “B”), between March 1, 2005 and the effective date of this rule shall begin testing on February 27, 2006 and shall be in production with the new record layouts no later than April 7, 2006.

~~1. Submitters who are electronically filing any medical reports with the division, as of the effective date of this rule, must complete a test transmission and be approved by the division for production transmission that meets the requirements set forth in the Florida Workers’ Compensation Medical EDI Implementation Guide, 2004 according to the following schedule:~~

~~a. August 2 through September 15, 2004, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with the letters A through E and that are submitting for multiple insurers, service companies or third party administrators.~~

~~b. September 16 through October 29, 2004, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with the letters F through Z and that are submitting for multiple insurers, service companies or third party administrators.~~

~~2. Submitters who are not electronically filing any medical reports with the division, as of November 1, 2004, must complete a test transmission and be approved by the division for production transmission that meets the requirements set forth in the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 according to the following schedule:~~

~~a. November 1 through December 15, 2004, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with A through H and that are submitting for multiple insurers, service companies or third party administrators.~~

~~b. December 16, 2004 through January 31, 2005, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with I through Q and that are submitting for multiple insurers, service companies or third party administrators.~~

~~c. February 1 through March 15, 2005, implementation of the test transmission to production transmission processes for all electronic form equivalents will include submitters with names beginning with R through Z and that are submitting for multiple insurers, service companies or third party administrators.~~

~~(b) Special Conversion to Electronic Reporting.~~

~~1. Submitters who have implemented electronic filing of any medical reports with the division within 120 calendar days prior to the effective date of this rule, shall be scheduled for the test transmission to production transmission processes, for all electronic form equivalents, to comply with requirements set forth in the Florida Workers' Compensation Medical EDI Implementation Guide, 2004, beginning February 1 through March 15, 2005.~~

2. The Division will, resources permitting, allow submitters that volunteer to complete the test transmission to production 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 Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005 ~~2004~~.

(b) Required data elements shall be submitted in compliance with the instructions and formats as set forth in the Florida Workers' Compensation Medical EDI Implementation Guide (MEIG), 2005 ~~2004~~.

~~(c)~~(d) The division will notify the insurer on the "Medical 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)~~(e) 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 request within 3 business days of the catastrophic failure to the division for approval to submit in an alternative reporting method and an alternative filing timeline

~~paper forms in order to meet division reporting requirements. The submission of paper forms due to a catastrophic failure shall not exceed 30 calendar days. Approval must be obtained from the Division's Office of Data Quality and Collection, 200 E. Gaines Street, Tallahassee, Florida 32399-4226. Approval to submit in an alternative reporting method and an alternative filing timeline paper forms shall be granted if a catastrophic event beyond the control of the submitter prevents electronic submission.~~

~~(f) Until March 16, 2005, required medical reports may be paper-form filed with the division by an insurer, service company or third party administrator as follows:~~

~~1. The insurer code number and service company/third party administrator code number (if applicable) accurately and legibly entered in the upper-right corner on the form.~~

~~2. The date insurer paid legibly stamped on the front of the form. Payments of \$0.00 are valid amounts on disallowed or denied charges.~~

~~3. The required data elements as set forth in record layout sections of the Florida Workers' Compensation Medical EDI Implementation Guide, 2004. An insurer shall submit to the division the listed information, legibly entered on the paper form, as follows:~~

~~a. Form DFS-F5-DWC-9.~~

~~I. "Procedure, Service or Supply Code" (as paid by the insurer, if different from billed code) — entered in Field 24D1 without obscuring the billed code;~~

~~II. "Procedure, Service or Supply Code Modifier" (as paid by the insurer, if different from billed modifier) — entered in Field 24D2 without obscuring the billed modifier;~~

III. ~~“Insurer Payment per Line” entered in Field 24K.~~

IV. ~~Additional data elements required pursuant to the Florida Workers’ Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

b. ~~Form DFS-F5-DWC-10.~~

I. ~~“Insurer Payment per Line”—written above the ‘Usual Charge’ in Field 15 or 19, respectively;~~

II. ~~Additional data elements required pursuant to the Florida Workers’ Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

c. ~~Form DFS-F5-DWC-11.~~

I. ~~“Insurer Payment per Line”—entered in Field 30 following description;~~

II. ~~Additional data elements required pursuant to the Florida Workers’ Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

d. ~~Form DFS-F5-DWC-90.~~

I. ~~“HCPCS/RATES” code (as paid by the insurer, if different from billed code).  
Enter the reimbursed code above the billed code;~~

II. ~~“HCPCS/RATES” code modifier (as paid by the insurer if different from billed modifier). Enter the reimbursed modifier above the billed modifier;~~

III. ~~“Insurer Payment per Line” entered in Locator 49;~~

~~IV. Additional data elements required pursuant to the Florida Workers' Compensation Medical EDI Implementation Guide, 2004 may be entered on the form, location to be determined by the insurer.~~

~~4. In order to facilitate the division's responsibility to determine the timeliness of health care provider reimbursement and submission of medical reports to the division, reports submitted in paper form must be submitted in batches and each batch must be accompanied with a cover sheet and the following requirements:~~

~~a. Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11 or DFS-F5-DWC-90 forms shall be separated by form type into 100-count batches prior to submitting to the division. Insurers, processing less than 100 forms in 30 calendar days shall separate by form type category and submit batches of less than 100.~~

~~b. Within each submitted paper form batch, the insurer shall separate and band into groups, medical reports as being untimely paid to a provider or untimely reported to the division pursuant to Section 440.20(6)(b), F.S., and paragraph (5)(e) of this rule, respectively.~~

~~c. Every submitted paper form batch shall be accompanied by a cover sheet providing the following information:~~

~~I. The title shall read "Medical Paper-Form Submission Cover Sheet".~~

~~II. The date the batch was submitted to the division shall be specified.~~

~~III. The insurer name, address including ZIP code of the medical claim office submitting the batch, insurer code number and service company third party administrator code number shall be specified.~~

~~IV. The insurer contact name, telephone number and email address shall be specified.~~

~~V. The form type (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90) shall be specified.~~

~~VI. The total number of medical reports in each batch submitted to the division shall be specified.~~

~~VII. The total number of medical reports filed with the division more than 45 calendar days after insurer payment, adjustment and payment, disallowance or denial shall be specified.~~

~~VIII. The total number of medical reports reflecting medical bills that were paid to the provider more than 45 calendar days from the date insurer received.~~

~~a. Every paper batch which is not accompanied by an accurately completed cover sheet or is not in compliance with sub-subparagraph (6)(f)4.a. of this rule, will be returned to the insurer, service company or third party administrator, and considered not in compliance with paragraph (5)(e) of this rule, until re-filed with an accurately completed cover sheet or correctly batched.~~

~~5. All required medical reports (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90) shall be submitted to the division at:~~

~~Department of Financial Services~~

~~Division of Workers' Compensation~~

~~Office of Data Quality and Collection, Medical Data Management Section~~

~~200 East Gaines Street~~

~~Tallahassee, FL 32399-4226.~~

~~(g) As an alternative to submitting paper form batches, as described in paragraph (6)(f) of this rule, medical data that would otherwise be provided on paper, between the effective date of this rule and each submitter's deadline for electronic submission according to the schedule in paragraph (6)(a) of this rule, may be filed in electronic format to the division in a Medical Summary Report to meet the requirements of this rule. A request to submit medical data in this format shall be sent to [ssmedrequest@dfs.state.fl.us](mailto:ssmedrequest@dfs.state.fl.us). Upon receiving written approval from the division via e-mail, each electronic Medical Summary Report shall be filed by a submitter as follows:~~

~~1. No later than 15 calendar days following the end of each calendar month, an insurer, service company or third party administrator shall submit four division-approved electronic Excel spreadsheets; one Excel spreadsheet for each of the four medical form types (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 and DFS-F5-DWC-90).~~

~~2. Each Excel spreadsheet must contain the following data elements:~~

~~a. Form Type (Forms DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11 or DFS-F5-DWC-90).~~

~~b. Calendar Month/Year of medical data processed by the insurer submitted to the division, (i.e. 01/01/2004 through 01/31/2004).~~

~~c. Name of Insurer, Service Company, or Third Party Administrator submitting the monthly division-approved electronic Excel spreadsheet.~~

~~d. Insurer code number, Service Company/Third Party Administrator code number submitting the monthly division-approved electronic Excel spreadsheet.~~

~~e. Contact Name, address, including ZIP code, telephone number and e-mail address of the Insurer, Service Company or Third Party Administrator,;~~

~~f. Total number of bills that were paid, adjusted and paid, disallowed or denied for the calendar month reported.~~

~~g. Total number of bills reported in sub-subparagraph f. above, that were paid, adjusted and paid, disallowed or denied more than 45 calendar days after the date insurer received the bill from the provider.~~

~~h. For each of the bills that were paid, adjusted and paid, disallowed or denied more than 45 calendar days after the date insurer received the bill from provider, the following additional data elements shall be provided on the division-approved electronic Excel spreadsheet:~~

~~(I) Injured Employee Last Name;~~

~~(II) Injured Employee First Name;~~

~~(III) Injured Employee SSN;~~

~~(IV) Claims Handling Entity File Number;~~

~~(V) Date of Accident;~~

~~(VI) Date Insurer Received Bill from Provider;~~

~~(VII) Date Insurer Paid, Adjusted and Paid, Disallowed, or Denied the Bill;~~

~~(VIII) Total Dollar Amount Paid by Insurer. If disallowed or denied, \$0.00 is to be reported; and~~

~~(IX) Provider License, Pharmacist or Other Facility number as assigned by the professional regulatory board, licensing authority or state regulatory agency, whichever is applicable depending on form type that is submitted.~~

~~(i) Each Insurer, Service Company, or Third Party Administrator approved to submit the electronic Medical Summary Report, shall submit the division-approved electronic Excel spreadsheets within the required time frame under subparagraph (6)(g)1. of this rule to [ssmedfomat@dfs.state.fl.us](mailto:ssmedfomat@dfs.state.fl.us).~~

(7) Insurer Administrative Penalties and Administrative Fines.

(a) Insurer administrative penalties for untimely provider-payment or disposition of medical bills. The department shall impose insurer administrative penalties for failure to comply with the payment, adjustment and payment, 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 ~~f~~Form category that was received within a specific calendar month.

(b) Insurer administrative fines for failure to submit, untimely submission, filing and reporting of medical data requirements. 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:

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

2. Imposed for each failure to file, untimely filed ~~un-filed~~, rejected and not re-submitted, or rejected and re-submitted untimely medical data report according to the following schedule:

- a. 1 – 15 calendar days late \$10.00;
- b. 16 – 30 calendar days late \$20.00;
- c. 31 – 45 calendar days late \$30.00;
- d. 46 – 60 calendar days late \$40.00;
- e. 61 – 75 calendar days late \$50.00;
- f. 76 – 90 calendar days late \$100.00; and
- g. 91 calendar days or greater ~~\$2500.00~~.

~~(c) An Insurer that fails to submit, or who untimely submits, any division-approved Medical Summary Report electronic Excel spreadsheet required in subparagraph (6)(g)1. of this rule, shall be assessed a penalty for improper filing of \$25.00 per day, not to exceed a total penalty of \$1,000.00 per improperly filed Excel spreadsheet, in addition to any administrative penalty pursuant to Section 440.20(6)(b), F.S.~~

*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), 440.20(6), 440.185(5), (9), 440.593 FS. History—New 1-23-95, Formerly 38F-7.602, 4L-7.602, Amended 7-4-04, \_\_\_\_\_.*