

DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF WORKERS' COMPENSATION

NOTICE OF PROPOSED RULEMAKING

RULE CH. NO.: RULE CH. TITLE:
69L-24 Workers' Compensation Insurers' Standards and Practices

RULE NO.: RULE TITLE:

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69L-24.004 Monitoring, Examining and Investigating

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PURPOSE AND EFFECT: Rule Chapter 69L-24, F.A.C., is being amended to concurrently repeal and replace all existing rules with new rules which have been restructured and renumbered to promote clarity regarding the establishment of uniform guidelines under which the Department of Financial Services, Division of Workers' Compensation will monitor, audit and investigate regulated entities to ensure compliance with statutory obligations under Chapter 440, Florida Statutes. The proposed rules provide guidance to regulated entities regarding requirements to provide timely payment of workers' compensation benefits to injured workers, to timely pay medical bills to providers, and to timely report workers' compensation data to the Department. Regulated entities include but are not limited to insurers, service companies, third-party administrators, self-serviced self-insured employers or funds, managing general agents, and data submitters that are responsible for adjusting workers' compensation claims or submitting information and data regarding those claims to the Department. The purpose and effect is also to establish uniform guidelines to penalize regulated entities for failure to provide timely payment of workers' compensation benefits to injured workers, for failure to timely pay medical bills to providers, and for failure to timely report workers' compensation information or data to the Department, based on findings made during the process of monitoring, auditing and investigating those regulated entities.

SUMMARY: Repeal of all existing rules in Rule Chapter 69L-24, F.A.C., and replacement of those rules with new rules which establish guidelines to monitor, audit and investigate regulated entities for compliance with the requirements of Chapter 440, Florida Statutes, regarding timely payment of benefits to injured workers, timely payment of medical bills, and timely reporting of data to the Department, and establish penalty guidelines for assessment of penalties for failure to comply with the statutory requirements.

SUMMARY OF STATEMENT OF ESTIMATED REGULATORY COSTS: No SERC has been prepared.

Any person who wishes to provide information regarding the statement of estimated regulatory costs, or to provide a proposal for a lower cost regulatory alternative, must do so in writing within 21 days of this notice.

RULEMAKING AUTHORITY: 440.13(11), 440.185, 440.20(6), 440.525(4), 440.591, 440.593(5), FS.

LAW IMPLEMENTED: 440.13(11), 440.185, 440.20(6), (8), 440.525, 440.593, FS.

IF REQUESTED IN WRITING WITHIN 21 DAYS OF THE DATE OF THIS NOTICE, A HEARING WILL BE HELD AT THE TIME, DATE, AND PLACE SHOWN BELOW (IF NOT REQUESTED, THIS HEARING WILL NOT BE HELD):

DATE AND TIME: Wednesday, August 5, 2009 @ 10:00 AM

PLACE: 104 J Hartman Bldg., 2012 Capital Circle S.E., Tallahassee, Florida.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE IS: Robin Ippolito, Bureau Chief, Bureau of Monitoring and Audit, Division of Workers' Compensation, Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399-4224, (850) 413-1775.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this program, please advise the Department at least 5 calendar days before the program by contacting the person listed above.

THE FULL TEXT OF THE PROPOSED RULE IS:

69L-24 Workers' Compensation Insurers' Standards and Practices

69L-24.001 Purpose

The purpose and intent of this rule chapter is to promote the self execution of the workers' compensation system through monitoring and enforcement of a regulated entity's fulfillment of its statutory obligations to provide timely payment of workers' compensation benefits to injured workers, to timely pay medical bills to providers, and to timely report workers' compensation medical data to the Department. The timely and accurate reporting of medical data is critical in that it enables the Department to provide current information about medical costs to policymakers and stakeholders so they can make qualitative and objective decisions relating to reimbursements to health care providers. Timely and accurate reporting of first reports of injury or illness is critical in that it allows the Department to monitor claims to ensure that regulated entities are fulfilling their statutory and rule obligations regarding the claims. The purpose of this rule chapter is also to establish performance standards and uniform guidelines for administrative fines and penalties assessed upon regulated entities for violations of Chapter 440 and other applicable Florida Statutes and Department Rules.

Rulemaking Authority 440.13(11), 440.185(10), 440.20(6), 440.525(4), 440.591, 440.593(5), FS. Law Implemented 440.13(11), 440.185, 440.20(6), (8), 440.525, 440.593, FS. History – New _____.

69L-24.002 Scope

This rule chapter applies to all regulated entities as defined in this rule chapter and applies to all violations discovered through monitoring, examining, or investigating. This rule chapter shall not be construed as creating any substantive violations not otherwise prescribed by statute or rule.

Rulemaking Authority 440.13(11), 440.185(10), 440.20(6), 440.525(4), 440.591, 440.593(5), FS. Law Implemented 440.13(11), 440.185, 440.20(6),(8), 440.525, 440.593, FS. History – New _____.

69L-24.003 Definitions

The following definitions shall apply in the rule chapter:

- (1) "Action" – an event or events leading to the commission of a violation.
- (2) "Audit" – a process whereby the practices of regulated entities are examined to verify compliance with Chapter 440 and other applicable Florida Statutes and Administrative Rules. The term "audit" is synonymous with the term "examination".
- (3) "Batch" – a group of data records that is created and evaluated by CPS from manually or electronically submitted data received by the Department.
- (4) "Centralized Performance System (CPS)" – a system that evaluates payment and filing data submitted to the Department.
- (5) "Department" – the Florida Department of Financial Services.
- (6) "Department Rules" – any and all rules adopted by the Department of Financial Services in its administration of Chapter 440 that apply to insurers or other regulated entities.
- (7) "Division" – the Division of Workers' Compensation within the Florida Department of Financial Services.
- (8) "Examination" – a process whereby the practices of regulated entities are examined to verify compliance with Chapter 440 and other applicable Florida Statutes and Department Rules. The term "examination" is synonymous with the term "audit".
- (9) "F.A.C." – Florida Administrative Code.
- (10) "F.S." – Florida Statutes.
- (11) "Form DFS-F2-DWC-1" – Form DFS-F2-DWC-1 (First Report of Injury or Illness) or an electronic equivalent as required in 69L-56, F.A.C.
- (12) "Investigation" – a Department review that is conducted to verify compliance with Chapter 440 and other applicable Florida Statutes and Department Rules.
- (13) "Pattern or Practice" – a repeated or customary act(s) of non-compliance with any single provision of Chapter 440 or other applicable Florida Statutes or Department Rules on an individual claim or on multiple claims.
- (14) "Regulated Entity" – any insurer as defined in Section 440.02(4), F.S., employer, service company, servicing agent, third-party administrator, claims handling entity, self-serviced self-insured employer or fund.

submitter of forms or data on behalf of an insurer, or managing general agent that is responsible for handling or adjusting claims, or fulfilling an insurer's responsibility to transmit workers' compensation data to the Department.

(15) "Violation" – any finding of non-compliance with Chapter 440 or other applicable Florida Statutes or Department Rules.

Rulemaking Authority 440.13(11), 440.185(10), 440.20(6), 440.525(4), 440.591, 440.593(5), FS. Law Implemented 440.13(11), 440.185, 440.20(6), (8), 440.525, 440.593, FS. History – New _____.

69L-24.004 Monitoring, Examining and Investigating

(1) The Department shall monitor, examine, or investigate the performance of regulated entities to ensure compliance with Chapter 440 and other applicable Florida Statutes and Department Rules as often as is deemed necessary.

(a) Monitoring includes, but is not limited to, the ongoing review of data provided to the Department by regulated entities.

(b) Examining or investigating includes, but is not limited to, the review of a regulated entity's processes and may be based upon:

1. the regulated entity's performance in prior examinations and/or investigations, or
2. information obtained through the monitoring process, or
3. information obtained through other methods utilized by the Department.

(2) Monitoring, examining, or investigating includes, but is not limited to, the review of the following:

(a) timeliness and accuracy of indemnity and/or medical payments,

(b) timeliness and accuracy of the filing of medical bill data,

(c) timeliness and accuracy of all forms required to be reported pursuant to 69L-3, F.A.C.,

(d) timeliness and accuracy of electronic transactions required by 69L-56, F.A.C.,

(e) denial of claims,

(f) delay in provision of benefits,

(g) harassment, coercion or intimidation of any party,

(h) evidence of the mailing and wording of the fraud statement pursuant to Section 440.105(7), F.S.,

(i) timeliness of the response to a Petition for Benefits,

(j) timeliness of the compliance with a Judge of Compensation Claim's order,

(k) timeliness of the compliance with a Department rule, order or directive,

(l) compliance with CPS batch timeframes,

(m) claims-handling practices,

(n) timeliness of medical authorizations,

(o) mailing of Form DFS-F2-DWC-65 (Important Workers' Compensation Information for Florida's Employers) or Form DFS-F2-DWC-66 (Informacion Importante Del Seguro De Indemnizacion Por Accidentes De Trabajo Para Los Empleadores De La Florida) to the employer,

(p) the date that Forms DFS-F2-DWC-60 or 61 (Important Workers' Compensation Information for Florida's Workers' brochure or Informacion Importante De Seguro De Indeminzacion Por Accidentes De Trabajo Para Los Trabajadores De La Florida) were mailed to the injured worker, and

(q) mailing of the Employee Notification Letter to the injured worker.

(3) Reports resulting from an examination or investigation conducted under Chapter 440 and other applicable Florida statutes and Department rules, are confidential and exempt from Section 119.07(1), F.S., pursuant to Section 624.319, F.S., until the examination or investigation ceases to be active.

Rulemaking Authority 440.13(11), 440.185(10), 440.20(6), 440.525(4), 440.591, 440.593(5), FS. Law Implemented 440.13(11), 440.185, 440.20(6), (8), 440.525, 440.593(5), FS. History – New _____.

69L-24.005 Maintaining and Providing Records

(1) Pursuant to Section 440.525(1), F.S., the Department may examine and investigate regulated entities as often as is warranted to ensure that they are fulfilling their obligations under Chapter 440, F.S. The Department shall have the power to conduct onsite inspections of claims records and documentation of an insurer, third-party administrator, servicing agent, or other claims-handling entity, and conduct interviews, both sworn and un-sworn, of claims-handling personnel. Insurers, third-party administrators, servicing agents, and other claims-handling entities shall make all claims records, documentation, communication, and correspondence available to Department personnel during regular business hours, pursuant to Section 440.525(3), Florida Statutes. All regulated entities shall provide to the Department all information and documentation that is requested for the purposes of monitoring,

examining, or investigating the regulated entity's operations and processes. Such information and documentation, including specific data, shall be made available to the Department within 14 calendar days of receipt of any request by the Department unless the Department allows an extension of time.

(2) For examinations or investigations, if the regulated entity maintains hard-copy files, the hard-copy files shall be made available to the Department on or before the date requested by the Department. If the regulated entity maintains electronic files and an examination or investigation is conducted at the regulated entity's offices, a sufficient number of functioning computers shall be made available to the Department for access to the electronic claims documents and information. Requests for information may include, but are not limited to:

(a) the date of notification or knowledge of the injury as defined in 69L-3.002(23) and 69L-56.002(35), F.A.C.

(b) the date of initial disability, the eighth day of disability and knowledge of the eighth day of disability,

(c) the date each indemnity payment was mailed to the injured worker, the amount of the payment, and the period of time that was covered in the payment,

(d) the date that Forms DFS-F5-DWC-9 (Health Insurance Claim Form/CMS-1500), DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form and Instructions), DFS-F5-DWC-11 (American Dental Association Dental Claim Form), and DFS-F5-DWC-90 (Hospital Billing Form (UB-04)), or their electronic equivalents, were received from the health care provider pursuant to 69L-7.602, F.A.C.

(e) the date that Forms DFS-F5-DWC-9 (Health Insurance Claim Form/CMS-1500), DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form and Instructions), DFS-F5-DWC-11 (American Dental Association Dental Claim Form), and DFS-F5-DWC-90 (Hospital Billing Form (UB-04)), or their electronic equivalents, were paid, disallowed, or denied,

(f) the date that Forms DFS-F5-DWC-9 (Health Insurance Claim Form/CMS-1500), DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form and Instructions), DFS-F5-DWC-11 (American Dental Association Dental Claim Form), and DFS-F5-DWC-90 (Hospital Billing Form (UB-04)), or their electronic equivalents, were mailed or transmitted to the Department,

(g) the date that Forms DFS-F2-DWC-60 or 61 (Important Workers' Compensation Information for Florida's Workers' brochure or Informacion Importante De Seguro De Indeminzacion Por Accidentes De Trabajo Para Los Trabajadores De La Florida) were mailed to the injured worker,

(h) the date that Form DFS-F2-DWC-65 or 66 (Employer Informational Brochure) was mailed to the employer,

(i) the date that the Employee Notification Letter was mailed to the injured worker,

(j) the date that any written request for medical authorization was received and the date that the medical authorization was granted in response to the written request,

(k) Electronic Data Interchange (EDI) transactions and requirements pursuant to Rule 69L-56, F.A.C.,

(l) the date that the 120-day notice required under Section 440.20(4), F.S. was mailed,

(m) all diary notes, claim notes, and correspondence available for review during an examination, audit or investigation.

Rulemaking Authority 440.13(11), 440.185(10), 440.20(6), 440.525(4), 440.591, 440.593(5), FS. Law Implemented 440.13(11), 440.185, 440.20(6), (8), 440.525, 440.593, FS. History – New _____.

69L-24.006 Administrative Penalties and Fines

The Department shall utilize the monitoring, examination, or investigation processes to ensure compliance with Chapter 440 and other applicable Florida statutes and Department rules. The Department may assess administrative penalties and fines for violations. Violations within this rule are described in general language. The use of general language shall not be construed to expand or modify the statute. Violations are not necessarily described herein using the language that would be used to formally assert the violation in any specific case.

(1) Indemnity Violations

(a) Late payments of compensation. In order to ensure insurer compliance under Chapter 440, F.S., the Department shall monitor, examine, and investigate the performance of insurers. The Department shall assess penalties for late payments of compensation that are below a minimum 95 percent timely payment performance standard. The insurer shall pay to the Workers' Compensation Administration Trust Fund a penalty of:

1. Fifty dollars per number of installments of compensation below the 95 percent timely payment performance standard and equal to or greater than a 90 percent timely payment performance standard.

2. One hundred dollars per number of installments of compensation below a 90 percent timely payment performance standard.

(b) Late filing of forms.

1. Employers shall be fined for each Form DFS-F2-DWC-1 which is not filed timely with the insurer or claims-handling entity as follows:

<u>Number of Days Late</u>	<u>Penalty for Untimely Filing</u>
<u>1-7 calendar days late</u>	<u>\$100 per form</u>
<u>8-14 calendar days late</u>	<u>\$200 per form</u>
<u>15-21 calendar days late</u>	<u>\$300 per form</u>
<u>22-28 calendar days late</u>	<u>\$400 per form</u>
<u>Over 28 calendar days late</u>	<u>\$500 per form</u>

2. The Division, through CPS, will calculate the penalties in order starting with the form with the greatest number of days late first. Insurers shall be fined for each DFS-F2-DWC-1 form which is not timely filed with the Department. Penalties shall be calculated for all the DFS-F2-DWC-1 forms that have been received by the Department in a specific CPS batch month as follows:

<u>Number of Days Late</u>	<u>Penalty for Untimely Filing</u>
<u>1-7 calendar days late</u>	<u>\$100 per form</u>
<u>8-14 calendar days late</u>	<u>\$200 per form</u>
<u>15-21 calendar days late</u>	<u>\$300 per form</u>
<u>22-28 calendar days late</u>	<u>\$400 per form</u>
<u>Over 28 calendar days late</u>	<u>\$500 per form</u>

3. After the insurer has accepted all penalties and submitted the batch to the Division for a specific month and the total amount of untimely filing penalties for that month exceeds \$10,000 as calculated under subparagraph (1)(b)1. and 2. herein, the penalty for each untimely filing not included in the calculation of the penalty up to \$10,000, shall be recalculated and assessed a penalty of \$25.00 per untimely filing for that specific month.

4. Insurers that incur untimely filing penalties issued through CPS in excess of \$10,000 for three or more specific months in a calendar year shall, in addition to penalties assessed, conduct quarterly self audits of their Form DFS-F2-DWC-1 filings to the Department documenting compliance by the insurer with the reporting requirements for Form DFS-F2-DWC-1, and submit the results of those audits to the Department documenting compliance with the reporting requirements for Form DFS-F2-DWC-1 for a one year period.

5. Any insurer that has been assessed penalties in excess of \$10,000 for a calendar month since January 1, 2008, until the effective date of this rule chapter, for untimely filing of Form DFS-F2-DWC-1, will have their penalty amount recalculated pursuant to subparagraph (1)(b)3. herein. If the insurer has already paid penalties to the Department for the untimely filing of Form DFS-F2-DWC-1, the Department shall refund the difference between the penalties paid and those recalculated under subparagraph (1)(b)3. herein, to the insurer, unless the insurer owes any outstanding, unpaid penalties to the Department. The outstanding, unpaid penalties must be paid in full prior to any refund being issued by the Department.

6. If the electronic First Report of Injury or Illness is assigned an Application Acknowledgement Code of Transaction Accepted (TA) within 30 days after the Claim Administrator, as defined in Rule 69L-56.002, F.A.C., is first approved and required by the Division to send electronic First Reports of Injury or Illness to the Division pursuant to paragraph 69L-56.300(1)(d), F.A.C., the insurer, as defined in Section 440.02(4), F.S., shall not be assessed a filing penalty pursuant to paragraph 69L-24.006 F.A.C., based on the filing requirements established in subsections 69L-56.301(1) and (2), F.A.C. After the completion of the 30 day period referenced above, all electronic First Reports of Injury or Illness must be assigned an Application Acknowledgement Code of Transaction Accepted (TA) by the Division within the required filing timeframes established in subsections 69L-56.301(1) and (2), F.A.C., to be considered timely filed.

(2) Medical Violations

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

1. The Department shall assess administrative penalties for failure to comply with the payment, adjustment, disallowance, or denial requirements pursuant to Section 440.20(6)(b), F.S. To evaluate the data for timely performance standards for timely payments, adjustments and payments, disallowances or denials, reported on Forms DFS-F5-DWC-9 (Health Insurance Claim Form/CMS-1500), DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Supplies Form and Instructions), DFS-F5-DWC-11 (American Dental Association Dental Claim Form), and DFS-F5-DWC-90 (Hospital Billing Form (UB-04)), or their electronic equivalents, the Department shall calculate penalties on a monthly basis for each separate form/category type that was received and accepted by the Department within a specific calendar month.

2. Pursuant to Section 440.20(6)(b), F.S., the Department shall calculate and assess administrative fines according to the following guidelines:

a. For medical services provided on or after January 1, 2004, insurers shall pay, disallow, or deny all medical,

dental, pharmacy, and hospital bills properly submitted to the insurer pursuant to Department rule no later than 45 calendar days after the insurer's receipt of the bill pursuant to Rule 69L-7.602. The Department shall assess penalties for payments, disallowances, or denials of medical, dental, pharmacy, and hospital bills that are below a minimum 95 percent timely performance standard. The insurer shall pay a penalty of:

i. \$25 for each bill below the 95 percent timely performance standard, but meeting a 90 percent timely performance standard.

ii. \$50 for each bill below a 90 percent timely performance standard.

(b) Insurer Administrative Penalties and Fines for Untimely Filing of Medical Bills.

1. Insurers that fail to submit a minimum of 95% of all medical bills timely for a specific month are subject to an administrative fine. Insurers shall be fined for medical bills which are not timely filed with the Department in accordance with the following procedure. For all untimely medical bills falling below the 95% requirement for a specific month, the Division, through CPS, will calculate the penalties for the untimely medical bills in order starting with the greatest number of days late first. Penalties for late filed medical bills shall be calculated in the batch month in which the medical bills are actually received by the Department, not the batch month in which the medical bills were required to be timely submitted, as follows:

<u>Number of Days Late</u>	<u>Penalty for Untimely Filing</u>
<u>1-30 calendar days late</u>	<u>\$5</u>
<u>31-60 calendar days late</u>	<u>\$10</u>
<u>61-90 calendar days late</u>	<u>\$25</u>
<u>91 or greater calendar days late</u>	<u>\$50</u>

2. After the insurer has accepted all penalties and submitted the batch to the Division for a specific month and the total amount of untimely filing penalties for that month exceeds \$10,000 as calculated under subparagraph (2)(b)1. herein, the penalty for each untimely filing not included in the calculation of the penalty up to \$10,000 shall be recalculated and assessed a penalty of \$5.00 per untimely filing for that specific month.

3. Insurers that incur untimely filing penalties issued through CPS in excess of \$10,000 for three or more specific months in a calendar year shall, in addition to penalties assessed, conduct quarterly self audits of their medical bill filings to the Department documenting compliance by the insurer with the reporting requirements for medical bills, and submit the results of those audits to the Department documenting compliance with the reporting requirements for medical bills for a one year period.

4. Any insurer that has been assessed penalties in excess of \$10,000 for a calendar month since January 1, 2008, until the effective date of this rule chapter, for untimely filing of medical bills, will have their penalty amount recalculated in accordance with subparagraph (2)(b)2. herein. If the insurer has already paid penalties to the Department for the untimely filing of medical bills, the Department shall refund the difference between the penalties paid and those recalculated under subparagraph (2)(b)2. herein, to the insurer, unless the insurer owes any outstanding, unpaid penalties to the Department. The outstanding, unpaid penalties must be paid in full prior to any refund being issued by the Department.

(c) Insurer Administrative Penalties and Fines for Rejected and not Resubmitted Medical Bills

1. Insurers are required to timely

correct medical bills that are rejected by the Department.

If the medical bill remains rejected and the insurer does not correctly resubmit the bill within 90 calendar days of the original rejected date, an administrative fine shall be assessed against the insurer in the amount of \$50 for each such medical bill.

(d) The provisions of Rule 69L-7.602(7) become null and void and are supplanted by penalty provisions in this amended rule chapter 69L-24 effective upon adoption of this amended rule chapter 69L-24.

Rulemaking Authority 440.13(11), 440.185(10), 440.20(6), 440.525(4), 440.591, 440.593(5), FS. Law Implemented 440.13(11), 440.185, 440.20(6), (8), 440.525, 440.593. FS. History – New _____.

69L-24.007 Pattern or Practice

(1) A pattern or practice constitutes a willful violation if the regulated entity that committed the pattern or practice:

(a) Did so intentionally and with knowledge of the act's unlawfulness or with disregard to the unlawfulness of the act; or,

(b) Failed to comply with an order of the Department and the insurer has exhausted all appellate rights.

(2) The penalties assessed under paragraph (1) of this rule shall be \$20,000 for a single willful violation and not exceed an aggregate of \$100,000 for all pattern or practice violations arising out of the same action.

(3) The Department may issue a non-willful violation for a pattern or practice of unreasonable claims handling for any monitoring, examining, or investigating review activity listed in Rule 69L-24.004(2), F.A.C., or for any other pattern or practice identified by the Department. For each such non-willful violation, a penalty of \$2,500 shall be assessed against the insurer by the Department, with such fines not exceeding an aggregate of \$10,000 for all pattern or practice violations arising out of the same action. Any penalty imposed under this paragraph for a non-willful violation shall not duplicate a penalty imposed under another provision of Chapter 440, Florida Statutes or Department Rules.

(a) The Department will calculate a regulated entity's performance in order to determine if a non-willful violation will be assessed for a pattern or practice of unreasonable claims handling. If the performance falls below 90% compliance during an audit, examination or investigation, except as otherwise stated in Chapter 440 and other applicable Florida Statutes and Department Rules, the Department may assess a penalty pursuant to paragraph (3) herein.

Rulemaking Authority 440.13, 440.185(10), 440.20(6), 440.525(4), 440.591, 440.593(5), FS. Law Implemented 440.13(11), 440.185, 440.20(6), (8), 440.525, 440.593, FS. History – New _____.

69L-24.021 – Minimum Performance Standards

~~A ninety percent (90%) rate of compliance is the minimum standard of performance for insurers, self insurers, employers and servicing agents in each of the following areas: timeliness in which they report and handle claims; promptness of payment of compensation benefits; and payment and disposition of medical bills. The 90% performance rate applies to all applicable insurers, self insurers, employers, and servicing agents who are subject to the following rules: Chapter 69L 3, F.A.C.; Chapter 69L 7, F.A.C.; or Chapter 38F 8, F.A.C. Specific Authority 440.20(8)(c), 440.13(11)(b), 440.591 FS. Law Implemented 440.20, 440.13(11) FS. History New 8-29-94, Formerly 38F 24.021, 4L 24.021, Repeal.~~

69L-24.0211 Monitoring

~~(1) The Division shall continually monitor the performance of insurers, self insurers, employers and servicing agents to ensure compliance with the performance standards prescribed in Rule 69L 24.021, F.A.C., and to assist these entities in improving their overall performance.~~

~~(2) Such monitoring will include the automated insurer performance system indicators as listed below:~~

- ~~(a) Timeliness and accuracy of all indemnity and medical payments;~~
- ~~(b) Timely and accurate reporting of required information;~~
- ~~(c) Volume and nature of employee complaints regarding the workers' compensation injury;~~
- ~~(d) Timeliness and accuracy of reporting coverage and changes in coverage;~~
- ~~(e) Compliance with rehabilitation status reviews and reporting requirements;~~
- ~~(f) Timeliness and accuracy of refunding overpayments;~~
- ~~(g) Effectiveness of utilization review program;~~
- ~~(h) Volume and cost of litigation in processing initial claims;~~
- ~~(i) Effectiveness in returning employees to work;~~
- ~~(j) Employee customer service ratings;~~
- ~~(k) Employer customer service ratings; and~~
- ~~(l) Amount of average medical costs and average total costs per claim.~~

~~In addition to the data in the Automated Insurer Performance System, review will be based on data received on referrals of questionable insurer practices received from other units of the Division, governmental entities, the Department of Financial Services, claimants, and other interested parties.~~

Specific Authority 440.20(15)(f), 440.591 FS. Law Implemented 440.20(15) FS. History New 8-29-94, Amended 5-14-95, Formerly 38F-24.0211, 4L-24.0211, Repeal.

69L-24.022—Auditing

(1) The audits by the Division will encompass all indicators covered by the Division's Automated Insurer Performance System as provided in Rule 69L-24.0211, F.A.C. However, insurers, self-insurers or servicing agents shall not be penalized for performance below 90 percent based on the following Automated Insurer Performance System indicators:

- (a) Volume and cost of litigation in processing initial claims;
- (b) Effectiveness in returning employees to work;
- (c) Employee customer service ratings;
- (d) Employer customer service ratings;
- (e) Amount of average medical costs and average total costs per claim; and
- (f) Volume and nature of employee complaints regarding the workers' compensation injury.

The Division will make recommendations to assist these entities to improve performance in the aforementioned areas for the specific purpose of rendering the Workers' Compensation system more effective and efficient.

(2) The Automated Insurer Performance System indicators and the other sources identified in this rule shall be reviewed by the Division to determine whether and how often to conduct audits of each insurer, self-insurer or servicing agent's practices. For purposes of this determination, substandard performance on any category outlined in Rule 69L-24.021, F.A.C., shall subject the entity to consideration for audit. No prior notice is required if the Division determines an audit is necessary. However, nothing set forth in these rules shall prohibit the Division from auditing all insurers, self-insurers and servicing agents at least once every three (3) years. Audits conducted under the three (3)-year requirement shall cover the preceding three (3) fiscal years of the insurer, self-insurer or servicing agent's operation and must commence within twelve (12) months after the end of the most recent fiscal year being covered by the audit. The audit may cover any period of the entity's operations since the Division's last audit.

(3) If the Division conducts an on-site audit of any insurer's, self-insurer's or servicing agent's practices, the audit report shall be utilized to recommend changes in such entity's behavior and to ensure its continuing compliance with the minimum performance standards set forth in this rule.

(4) For purposes of this rule:

(a) On-Site audits will be conducted at the physical location of the entity being audited. The Division shall issue a written audit report within thirty (30) days after conclusion of an on-site audit conducted pursuant to this rule. This report shall include the Division's recommendations for improving the entity's overall performance in all categories as specified by the Automated Insurer Performance System.

(b) Desk audits will be conducted at the Division's office based on data reported to the Division. A written audit report shall be issued at any time the entity's performance is below the minimum performance standard.

(5) All insurers, self-insurers or servicing agents shall provide the Division with all information relevant to each case file and the Automated Insurer Performance System indicators, as needed, to permit a complete review of the entity's operations and processes during an audit. Such information may be furnished through hard copy or through a computerized format, as long as the information is made available to the Division at the time of the audit. In the event the information is kept in a format other than hard copy, such format shall be accessible by the Division without unreasonable delay caused by access codes or the programming of access codes for entry into the entity's database by the Division.

Specific Authority 440.13(11)(b), 440.20(8)(c), (17), 440.591 FS. Law Implemented 440.13(11), 440.20 FS. History New 8-29-94, Amended 5-14-95, Formerly 38F-24.022, 4L-24.022, Repeal.

69L-24.0222—Re-Audit and Certification for Noncompliance

(1) Any insurer, self-insurer or servicing agent who fails to achieve at least 90 percent compliance on any initial audit shall be audited again within twelve (12) months of the date of the initial audit. During the re-audit, the Division shall examine the entity's performance based on the deficiencies identified in the initial audit report and the specific action proposed for eliminating the deficiencies in the entity's Statement of Objectives. Once the entity has been re-audited and determined not to satisfy the 90 percent compliance rate, that entity shall be subject to the following sanctions:

(a) If the entity's performance is below 90 percent compliance due to its failure to carry out the specific action proposed, it shall be certified to the Department of Financial Services or this Division, as applicable, under Section 440.20(15)(a), Florida Statutes, in addition to any penalty or fine authorized under Rule 69L-24.0221, F.A.C.

(b) All insurers, self insurers, or servicing agents failing to submit a Statement of Objectives and who do not achieve at least 90 percent compliance on re-audit shall be certified to the licensing authority, in addition to any penalty or fine authorized under Rule 69L-24.0221, F.A.C.

(2) Any insurer, self insurer or servicing agent whose initial audit indicates a failure to achieve at least 50 percent compliance, shall be certified to the Department of Financial Services or this Division, as applicable, under Section 440.20(15)(a), Florida Statutes.

(3) Upon conclusion of any on-site audit, the Division's personnel conducting the audit shall review the preliminary findings of such audit with the claims manager or the individual in charge of the office being audited or his designee. Insurers that will be sanctioned under subsection (2) of this rule may request that Division personnel hold, or cause to be held, a workshop which shall include, but not be limited to, the areas of deficiency identified in the audit.

(4) The Division shall not re-audit an insurer, self insurer, or servicing agent for failure to achieve 90 percent compliance with the Automated Insurer Performance System indicators set forth in paragraphs 69L-24.0221(1)(a)-(f), F.A.C.

Specific Authority 440.13(1)(b), 440.20(15)(f), 440.591 FS. Law Implemented 440.20 FS. History New 8-29-94, Amended 5-14-95, Formerly 38F-24.0222, 4L-24.0222, Repeal.

69L-24.0231 Benefits and Administration Trust Fund Penalties Improper Filing Practices

(1)(a) Failure to timely file, by electronic or paper submission, legible and complete forms, reports, or documents as required by Chapter 440, F.S., Chapter 69L-3, F.A.C., or other Division rules implementing Chapter 440, F.S., shall subject the party required to file such form, report or document to assessment by the Division of an Administrative fine. For purposes of this rule, a paper form, report or document is timely filed when it is postmarked and mailed prepaid prior to the expiration of the time periods prescribed in this rule, and Chapter 69L-3, F.A.C. For purposes of this rule, if disability is immediate and continuous for 8 or more calendar days after the injury, an electronic equivalent of a First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division on or before the 21st day after the insurer's knowledge of the injury and is assigned an acknowledgement code of Transaction Accepted (TA). If the first 7 days of disability are nonconsecutive or delayed, the electronic equivalent of a First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division on or before the 13th day after the insurer's knowledge of the 8th day of disability and is assigned an acknowledgement code of Transaction Accepted (TA). Penalties shall be assessed as follows:

(b) DWC 1, First Report of Injury or Illness. Employers shall be penalized for each DWC 1 that is not timely filed with the insurer or servicing agent as follows:

1. \$100 for one through seven days of untimely filing;
2. \$200 for eight through 14 days of untimely filing;
3. \$300 for 15 through 21 days of untimely filing;
4. \$400 for 22 through 28 days of untimely filing; or
5. \$500 for over 28 days of untimely filing.

(c) Insurers shall be penalized for each DWC 1 that is not timely filed with the Division as follows:

1. \$100 for one through seven days of untimely filing;
2. \$200 for eight through 14 days of untimely filing;
3. \$300 for 15 through 21 days of untimely filing;
4. \$400 for 22 through 28 days of untimely filing; or
5. \$500 for over 28 days of untimely filing.

(d) If the electronic First Report of Injury or Illness is assigned an Application Acknowledgement Code of Transaction Accepted (TA) within 30 days after the Claim Administrator, as defined in Rule 69L-56.002, F.A.C., is first approved and required by the Division to send electronic First Reports of Injury or Illness to the Division pursuant to paragraph 69L-56.300(1)(d), F.A.C., the Insurer, as defined in Rule 69L-56.002, F.A.C., shall not be assessed a filing penalty pursuant to paragraph 69L-24.0231(1)(c), F.A.C., based on the filing requirements established in subsections 69L-56.301(1) and (2), F.A.C. After the completion of the 30 day period referenced above, all electronic First Reports of Injury or Illness must be assigned an Application Acknowledgement Code of Transaction Accepted (TA) by the Division within the required filing timeframes established in subsections 69L-56.301(1) and (2), F.A.C., to be considered timely filed.

(2) Improper Disposition of Medical Bill Penalties. Any penalty imposed on an insurer or self-insured for the improper disposition of medical bills when such disposition is below 90 percent compliance, after 7-1-94, shall be

assessed, per quarter, as follows:

80% through 89.99%	1/4 percent of the prior year's assessment levied under Section 440.51, F.S., against the entity being fined.
70% through 79.99%	1/2 percent of the prior year's assessment levied under Section 440.51, F.S., against the entity being fined.
60% through 69.99%	3/4 percent of the prior year's assessment levied under Section 440.51, F.S., against the entity being fined.
0% through 59.99%	1 percent of the prior year's assessment levied under Section 440.51, F.S., against the entity being fined.

~~(3)(a) Penalty to the Administration Trust Fund. Any fine imposed on any insurer or servicing agent that is payable to the Administration Trust Fund for untimely payment of compensation benefits which were paid on or after 1-1-94 shall be as follows:~~

~~(b) \$50 for each late payment of compensation which is below 90 percent compliance not to exceed one percent of the prior year's assessment levied under Section 440.51, F.S.;~~

~~(4) Benefit Penalty without an Award. Any penalty payable to the employee for the untimely payment of compensation benefits, on dates of accident on or after 1-1-94, payable without an award, shall be as follows:~~

~~(a) 20 percent on the first of any late installments of compensation not paid within seven days after it becomes due;~~

~~(b) \$5 per subsequent installment of compensation not paid within seven days after it becomes due; and~~

~~(c) For dates of accident prior to 1-1-94, the penalty shall be the greater of 10 percent or \$5 for any installment of compensation not paid within 14 days after it becomes due.~~

~~(5) Benefit Penalty with an Award. Any penalty for the untimely payment of compensation for dates of accident on or after 1-1-94 payable under the terms of an award shall be 20 percent of such unpaid compensation not paid within 37 days after the date the order is mailed to the parties, unless review of the compensation order making such award is taken as provided in Section 440.25, F.S. For dates of accidents prior to 1-1-94, the penalty shall be 20 percent of such unpaid compensation not paid within 60 days after the date the order is mailed to the parties, unless review of the compensation order making such award is taken as provided in Section 440.25, F.S.~~

~~(6) When a servicing agent is under contract with a insurer to fulfill the insurer's administrative responsibilities under this chapter, the payment practices of the servicing agent are deemed the payment practices of the insurer, in which case the insurer shall be the responsible party for any penalties assessed under this section.~~

~~Specific Authority 440.13(11)(b), 440.185, 440.591, 440.593(5) FS. Law Implemented 440.13(11)(b), 440.185(9), 440.20(8)(a) FS. History New 8-29-94, Amended 5-14-95, 6-4-97, 11-28-01, Formerly 38F-24.0231, 4L-24.0231, Amended 1-8-04, 5-8-08, Repeal.~~

69L-24.024 Medical Penalties

~~(1) Penalty for Willful Refusal to Provide Medical Records or to Discuss Medical Condition. The Division, pursuant to Chapter 69L-7, F.A.C., shall assess a penalty against a health care provider who willfully refuses to provide medical records or to discuss the medical condition of the injured employee, after a reasonable request is made by the Division, employer, insurer or attorney for either of them for such medical records or to discuss the medical condition of the injured employee.~~

~~(2)(a) Failure to Timely Compensate a Certified Expert Medical Advisor. The Division shall assess a penalty which shall not exceed \$500 against any insurer, self insurer or servicing agent that fails to timely compensate a certified expert medical advisor for services rendered, pursuant to Section 440.13(9), Florida Statutes. In accordance with Section 440.13(9)(f), Florida Statutes, the Division establishes the following penalty schedule, with \$500 being the maximum penalty for each failure to timely compensate such advisor.~~

~~(b) Payment by the insurer, self insurer or servicing agent to a certified expert medical advisor is deemed timely when such payment is made within 45 calendar days after the date the insurer, self insurer or servicing agent receives the expert medical advisor's bill for services rendered.~~

~~1. One through five calendar days of untimeliness in payment will result in a penalty of \$200;~~

~~2. Six through ten calendar days of untimeliness in payment will result in a penalty of \$400;~~

~~3. Over 10 calendar days of untimeliness in payment will result in a penalty of \$500.~~

~~(3) Failure of Health Care Provider To Refund Overpayment Within 30 Days After Notification. The Division, pursuant to Chapter 69L-7, F.A.C., shall assess a penalty against any health care provider who fails to refund an~~

overpayment made by the insurer, self insurer or servicing agent within 30 days after receipt of written notification with substantiation of the overpayment by either the insurer, self insurer, servicing agent or the Division of Workers' Compensation.

Specific Authority 440.13(11)(a), 440.20(8)(c), 440.591 FS. Law Implemented 440.13(9)(f), (11) FS. History New 8-29-94, 5-14-95, Formerly 38F 24.024, 4L 24.024, Repeal.

69L-24.0241 Employee Failure to Appear for Independent Medical Examination

The insurer may contact the injured employee directly to schedule a reasonable time for an independent medical examination. The insurer has an obligation to confirm, in writing, the date and time of such examination to the injured employee within five days of the date and time the insurer and employee agreed to such examination. The insurer must also notify the injured employee's counsel, if any, of such examination no later than seven days prior to the date such examination is scheduled.

(1) For purposes of this section, "reasonable time" means a time acceptable to both parties.

(2) Injured employees are required to appear for all properly scheduled independent medical examinations, unless the injured employee can provide good cause for his absence. For purposes of this section, good cause can be established by showing that an immediate illness, injury, unforeseen event or intervening circumstances prevented the injured employee's appearance. An injured employee who does not properly provide at least 24 hours' notice of cancellation and cannot demonstrate good cause for his/her nonappearance for the independent medical examination shall not be excused from the sanctions of subsections (3) and (4) below.

(3) An injured employee who fails without good cause, as set forth above, to appear for the scheduled independent medical examination shall reimburse the insurer 50 percent of the cancellation or no show fee. The insurer may withhold no more than 20 percent of each bi-weekly installment amount payable to the injured employee when recouping from the injured employee a cancellation or no show fee that has been paid by the insurer. The insurer shall not recoup more than 50 percent of the actual cancellation or no show fee.

(4) An injured employee who fails, without good cause as set forth in subsection (2), to appear for the scheduled independent medical examination is barred from recovering compensation for any period during which the injured employee has refused to submit to such examination. Compensation under this paragraph means indemnity benefits. *Specific Authority 440.591 FS. Law Implemented 440.13(5)(d) FS. History New 8-29-94, Amended 5-14-95, Formerly 38F 24.0241, 4L 24.0241, Repeal.*

NAME OF PERSON ORIGINATING PROPOSED RULE: Robin Ippolito, Bureau Chief, Bureau of Monitoring and Audit, Division of Workers' Compensation, Department of Financial Services

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE:

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DATE PROPOSED RULE APPROVED BY AGENCY HEAD: May 25, 2009

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAW: March 20, 2009