

DEPARTMENT OF FINANCIAL SERVICES  
DIVISION OF WORKERS' COMPENSATION

NOTICE OF PROPOSED RULE DEVELOPMENT

RULE CH. NO.:	RULE CHAPTER TITLE:
<u>69L-34, F.A.C.</u>	<u>Carrier Report of Health Care Provider Violations</u>
RULE NO:	RULE TITLE:
<u>69L-34.001, F.A.C.</u>	<u>Definitions</u>
<u>69L-34.002, F.A.C.</u>	<u>Mandatory Carrier Reporting</u>
<u>69L-34.003, F.A.C.</u>	<u>Referral of Alleged Health Care Provider Violation</u>
<u>69L-34.004, F.A.C.</u>	<u>Timeliness of Referral</u>
<u>69L-34.005, F.A.C.</u>	<u>Referral Investigation</u>
<u>69L-34.006, F.A.C.</u>	<u>Invalid Referrals</u>

PURPOSE AND EFFECT: The purpose and effect of this proposed rule is to:

1. Clarify that the mandatory reporting of all instances of overutilization to the Division of Workers' Compensation (Division) shall be accomplished by means of the Carrier's compliance with the Division's medical claims information filing requirements in Rule 69L-7.602(5) and (6), Florida Administrative Code (F.A.C.), Florida Workers' Compensation Medical Services Billing, Reporting and Filing Rule; and

2. Introduce a discretionary reporting process by which Carriers may report to the Division, a Health Care Provider's violation of Chapter 440, Florida Statutes (F.S.), and applicable administrative rules.

SUBJECT AREA TO BE ADDRESSED: The process by which a Carrier shall comply with mandatory reporting requirements set forth in Section 440.13(8)(a), F.S., and the procedure by which a carrier may also report to the Division other Health Care Provider violations as specifically defined in this rule.

RULEMAKING AUTHORITY: 440.13(13)(g), 440.591, F.S.

LAW IMPLEMENTED: 440.13(4), (7), (8), (11), (13), (14), (16), 440.192, F.S.

IF REQUESTED IN WRITING AND NOT DEEMED UNNECESSARY BY THE AGENCY HEAD, A RULE DEVELOPMENT WORKSHOP WILL BE HELD AT THE TIME, DATE, AND PLACE SHOWN BELOW:

DATE AND TIME: Wednesday, December 2, 2009 @ 9:00 AM

PLACE: 104J Hartman Building, 2012 Capital Circle Southeast, Tallahassee, Florida.

THE PERSON TO BE CONTACTED REGARDING THE PROPOSED RULE DEVELOPMENT AND A COPY OF THE PRELIMINARY DRAFT, IF AVAILABLE, IS: Eric Lloyd, Office of Medical Services, Division of Workers' Compensation, Department of Financial Services, 200 East Gaines Street, Tallahassee, Florida 32399-4232, (850) 413-1689, Eric.Lloyd@myfloridacfo.com.

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 PRELIMINARY TEXT OF THE PROPOSED RULE DEVELOPMENT IS:

**69L-34.001, F.A.C. Scope**

As used in this Rule Chapter:

(1) "Carrier" is as defined in Section 440.13(1)(c), Florida Statutes ( F.S.).

(2) "Division" means The Department of Financial Services Division of Workers' Compensation.

(3) "Health Care Provider" (hereinafter referred to as "Provider") is as defined in Section 440.13(1)(h), F.S., and includes those that consent to the jurisdiction of the Division pursuant to Section 440.13(3)(f), F.S.

(4) "Verifiable delivery process" is defined as the ability to document a common carrier's pick- up date or a United States Postal Services postmark date.

(5) "Violation" is defined as a Provider's non-compliance with Chapter 440, F.S. and Division rules, which shall include: failing to submit medical records and reports pursuant to Section 440.13(4)(a) and (c), F.S.; failing to refund an overpayment of reimbursement, pursuant to Section 440.13(11)(a), F.S.; collecting or receiving payment from an injured employee in violation of Section 440.13(14)(a), F.S.; or failing to follow standards of care, pursuant to Section 440.13(16), F.S., including overutilization of services.

(6) "Improper billing and billing errors" means the failure of a Provider to comply with the Division's billing and reporting requirements pursuant to Rule 69L-7.602, Florida Administrative Code (F.A.C.), and the applicable reimbursement manual(s).

Rulemaking Authority 440.13(13)(g), 440.591, F.S. Law Implemented 440.13, F.S. History-New

**69L-34.002, F.A.C. Mandatory Carrier Reporting**

A Carrier shall report to the Division, pursuant to Section 440.13(8), F.S., all instances of overutilization and improper billing and billing errors, including all instances in which the Carrier disallows or adjusts payment, by timely filing the required medical claims data elements with the Division, as required in Rules 69L-7.602(5) and (6), F.A.C.

Rulemaking Authority 440.13(13)(g), 440.591, F.S. Law Implemented, 440.13(8), F.S. History-New

**69L-34.003, F.A.C. Referral of Alleged Health Care Provider Violation**

(1) A Carrier who wishes to make a written report of a Provider violation, as defined in this chapter, directly to the Division's Office of Medical Services shall use the Health Care Provider Violation Referral Form (Form DFS-F6-DWC-2000) (hereinafter "Referral Form"). The Referral Form is hereby incorporated by reference.

(2) A Carrier shall submit a separate Referral Form for each alleged violation.

(3) A Carrier shall serve a copy of the Referral Form on the Provider utilizing a verifiable delivery process, such as United States Postal Service certified mail or similar process offered by a common carrier.

(4) Carrier reporting of violations under this rule does not remove or satisfy the Carrier's mandatory reporting obligation under Rules 69L-7.602 and 69L-34.002, F.A.C.

Rulemaking Authority 440.13(13)(g), 440.591, F.S. Law Implemented 440.13(4), (8), (11), (14), (16), 440.192, F.S. History-New

**69L-34.004, F.A.C. Timeliness of a Referral**

(1) A properly completed Referral Form, filed with any and all documentation that supports the alleged violation, must be received by the Division no later than 180 days after the Carrier's Explanation of Bill Review, as defined in Rule 69L-7.602, F.A.C., or other form of initial notification to the Provider identifying the occurrence of an alleged violation.

(2) The initial notification of the occurrence of an alleged violation may be via an electronic or written notice sent to the Provider.

Rulemaking Authority 440.13(13)(g), 440.591, F.S. Law Implemented 440.13(8), F.S. History-New

**69L-34.005, F.A.C. Referral Investigation**

(1) A Division investigation of an alleged violation may result from:

(a) An audit of medical bill data filed with the Division; or

(b) The receipt of a completed Referral Form and all supporting documentation; or

(c) A combination of subparagraphs (a) and (b) above.

(2) The Carrier and Provider shall submit to the Division, within forty-five (45) days of receipt of a document request from the Division, all additional documentation that the Division may request as a part of its investigation. If any of the requested documentation is not included in the Carrier's or Provider's response to the Division's document request, the Carrier or Provider must submit a specific written explanation as to the reason(s) the documentation was not included.

(3) If either the Carrier or the Provider fail to timely submit the requested documentation or specific written explanation as to the reason the additional documentation can not be provided, the Division, in its exclusive jurisdiction pursuant to Section 440.13(11)(c), may close the investigation or issue its findings based on the documentation initially filed with the Referral Form and any responses appurtenant thereto that were timely received.

(4) The Division shall not issue a penalty for Provider violations under this chapter except following an investigation pursuant to this rule; however, if the Division finds a provider has engaged in a violation, administrative penalties, fines or other sanctions shall be issued in accordance with Section 440.13(8), (11), and (13), F.S.

Rulemaking Authority 440.13(13)(g), 440.591, F.S. Law Implemented 440.13(8), (11), (13), F.S. History New

**69L-34.006, F.A.C. Invalid Referrals**

(1) A Carrier may not submit a Referral Form to report to the Division an alleged violation related to:

(a) A reimbursement dispute in which the Carrier has waived any objection, pursuant to Section 440.13(7)(b), F.S. to a petition filed by the Provider.; or

(b) A Petition for Benefits pending before a Judge of Compensation Claims for a determination of the medical necessity of services and treatment recommended or rendered by the Provider.

(2) A referral related to issues identified in section (1) is invalid and will not be investigated.  
Rulemaking Authority 440.13(13)(g), 440.591, F.S. Law Implemented 440.13(7), (8), 440.192, F.S. History-  
New\_\_\_\_\_.