

OMS Frequently Asked Questions

HCP CERTIFICATION

- Q.** What is the definition of a health care provider (HCP)?
- A.** A health care provider is a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision or direction of a physician and who has been certified by the department as a health care provider. The term "health care provider" includes a health care facility,
- Q.** What is a certified health care provider?
- A.** A certified health care provider is a health care provider who has been certified by the department or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers under this section. Certification of such health care provider must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance
- Q.** Is certification as a health care provider required for participation in the FL WC health care delivery system?
- A.** A health care provider who renders services under this program **must be** a certified health care provider as a condition to eligibility for payment under this chapter,
- Q.** Who is eligible for certification as a health care provider (HCP) by the Department of Financial Services, Division of Workers' Compensation (Division)?
- A.** The following providers may render services under the FL WC health care delivery system as certified health care providers:
- Any physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, a podiatric physician licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, Florida Statutes (F.S.):
 - Any non-physician health care provider licensed by the Department of Health who works under the protocol of a physician or who, upon referral from a physician, can render direct billable services independent of the supervision of a physician;
 - Any hospital licensed under chapter 395 and any health care institution licensed under chapter 400 or chapter 429.

- Any health care provider that has entered an agreement with a licensed managed care organization to provide treatment to injured workers.

Q. Does the Division offer training on the statutory and rule requirements for participation in the FL WC health care delivery system

A. The Division's Health Care Provider (HCP) Tutorial provides training on all applicable rules and policies that the HCP with which the HCP needs familiarity to participate as a certified HCP.

Q. How does a provider apply to become a certified health care provider?

A. A provider meeting the requirements of [69L-29.002, F.A.C.](#), must forward a properly completed and signed Health Care Provider Certification Form [DFS-3160-0020](#) to the address provided on the certification form.

Q. Can a provider be required to refund a workers' compensation insurer an overpayment of reimbursement?

A. Florida Statutes requires a health care provider to refund reimbursement, paid in error as the result of the provider improper billing or overutilization of services, to the workers' compensation insurer. The refund is due within 30 days of receipt of notification by the workers' compensation insurer or the Division that a refund is owed. Failure to refund such payment is subject to the imposition of penalties by the Division, [s. 440.13\(11\)\(a\), F.S.](#)

EXPERT MEDICAL ADVISORS

Q. Does the Florida Workers' Compensation system utilize physicians to render expert professional opinions in legal proceedings?

A. Expert Medical Advisor (EMA) are utilized by the division to provide peer review or expert medical consultation, opinions, and testimony to the department or to a judge of compensation claims in connection with resolving disputes relating to reimbursement, differing opinions of health care providers, and health care and physician services rendered under this chapter, including utilization issues.

Q. What are the qualification requirements to become certified as an EMA?

A. To qualify for EMA certification, a physician must, at a minimum, hold clear and active licensure from the Florida Department of Health; have been a certified health care provider for two years prior to the EMA application date and meet all other eligibility requirements provided in Rule 69L-30, F.A.C.

- Q.** How does a provider apply for EMA certification?
- A.** A certified health care provider must meet the eligibility requirements provided in Rule [69L-29](#), F.A.C. and submit a completed and signed DFS-F5-DWC 3160.0021 form accompanied by proof of eligibility.

PROVISION OF MEDICAL SERVICES; AUTHORIZATION

- Q.** What services are authorized under the Florida Workers' Compensation system?
- A.** Any service medically necessary to treat the compensable condition may be authorized by the workers' compensation insurer. The service or treatment must not be investigational or experimental in nature.
- Q.** What does medically necessary or medical necessity mean?
- A.** "Medically necessary" or "medical necessity" means any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature.
- Q.** Are there limitations on the level, duration, intensity and frequency of services rendered to an injured employee?
- A.** No. If a service is medically necessary and such treatment conforms to the standards of care that require "all treatment [to] be inherently scientifically logical", and the evaluation or treatment procedure must match the documented physiologic and clinical problem. Treatment shall match the type, intensity, and duration of service required by the problem identified."
- Q.** Is a health care provider required to obtain prior authorization to treat an injured employee?
- A.** Yes, except in emergency situations. As a condition of reimbursement, a provider must obtain authorization from the workers' compensation insurer prior to rendering medical treatment and services. Prior authorization is not required to render emergency treatment.

DOCUMENTING MEDICAL CONDITION STATUS/PROPOSED TREATMENT PLANS

- Q.** What documentation is required to be submitted by from the health care provider to the workers' compensation insurer to report the medical status and treatment recommended or rendered to the injured employee?
- A.** The provider must submit a Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form [DFS-F5-DWC-25](#), to request authorization of the treatment plan, referral to specialists, and to communicate the injured employee's medical condition and return to work status.
- Q.** Under what condition can the workers' compensation insurer not approve the provider's treatment plan?
- A.** An workers' compensation insurer must authorize a provider's treatment plan unless the health care provider or facility is not authorized or certified, unless such treatment is not in accordance with the standards of care provisions established in this chapter, or unless a judge of compensation claims has determined that the consultation, treatment or procedure is not medically necessary, not in accordance with the standards of care provisions established in this chapter, or otherwise not compensable under this chapter.
- Q.** May a provider refer an inured employee to another provider without prior authorization from a workers' compensation insurer?
- A.** No, a health care provider may not refer the employee to another health care provider, diagnostic facility, therapy center, or other facility without prior authorization from the insurer, except when emergency care is needed. Any referral must be to a health care provider that has been **certified** pursuant to [69L-29.002, F.A.C.](#) by the department, unless the referral is for emergency treatment, and that referral must be made in accordance with the standards of care provisions as provided in this chapter

REIMBURSEMENT DISPUTES AND NON-PAYMENT ISSUES

REIMBURSEMENT DISPUTES

- Q.** How does a health care provider file a complaint when the provider disagrees with the amount of reimbursement issued by the workers' compensation insurer?
- A.** If the provider disagrees with a workers' compensation insurer's reimbursement decision, the provider may contest the reimbursement by filing a [Petition for Resolution of Reimbursement Dispute](#) with the Division.

Q. Is there a time limit when the provider may file a Petition Resolution of Reimbursement Dispute?

A. Yes. The provider must file a Petition for Resolution of Reimbursement Dispute Form, [DFS-3160-0023](#), with the Office of Medical Services within 30 days of receiving a notice of disallowance or adjustment of payment (Explanation of Bill Review, EOBR) from the workers' compensation insurer. Rule [69L-31](#), F.A.C. provides the specific requirements to be met by the provider when filing a petition.

Q. What constitutes a valid petition?

A. The petitioner must:

- Serve the petition on the Division of Workers' Compensation, Office of Medical Services (OMS) within 30 days of receipt of a notice of payment, adjustment to payment or disallowance of payment; and
- Serve a copy of the petition and all documentation submitted with the petition to the workers' compensation insurer by United States Postal Service certified mail; and
- Submit all required documentation, pursuant to Rule [69L-31.005](#); and
- Submit all documentation needed to substantiate the petitioner's allegations.

Q. Is the provider required to notify the workers' compensation insurer that a petition has been filed?

A. Pursuant to s. 440.13(7)(a), Florida Statutes and Rule [69L-31.007](#), F.A.C., the provider is required to send, by certified mail, the workers' compensation insurer a copy of the petition and all accompanying documentation filed with the Division of Workers' Compensation, Office of Medical Services.

Q. What is a Notice of Deficiency?

A. A Notice of Deficiency (Notice) document will be issued by the Division of Workers' Compensation, Office of Medical Services in response to a petition received with omissions of required documentation or omission of entries on the petition form. The submitter will have 10 days from date of receipt of the Notice to submit curative documentation to the OMS and serve a copy of the curative documentation upon the carrier via United States Postal Service certified mail.

Q. What will happen if the petitioner fails to cure the deficiency, fails to respond within 10 days from receipt of the Notice of Deficiency, or fails to serve a copy of the curative documentation on the insurer (carrier)?

A. The petition deficiencies are deemed uncured and the petition is dismissed.

Q. What is the purpose of the Explanation of Bill Review (EOBR)?

- A. The EOBR is the workers' compensation insurer's official notification to the health care provider of the reimbursement decisions to pay, disallow or adjust reimbursement. The insurer is required to explain the reimbursement for each billed line item by using the EOBR codes (listed in Rule [69L-7.602\(5\)\(o\)](#), F.A.C.) that best describe the insurer's reimbursement decision.
- Q. Can a determination rendered by the Division of Workers' Compensation, Office of Medical Services be contested by either party to the reimbursement dispute?
- A. The provider or the workers' compensation insurer, or the entity designated to represent the provider or insurer, may contest the Division's determination by filing a request for administrative hearing under [Chapter 120, Florida Statutes](#).

NON-PAYMENT ISSUES

- Q. What can a provider do if a workers' compensation insurer fails to respond to the health care provider's request for payment of services?
- A. A provider can file a non-payment complaint with the Division of Workers' Compensation, Office of Medical Services for a determination of the provider's entitlement to reimbursement.
- Q. What is a non-payment complaint?
- A. A [non-payment](#) complaint is a provider allegation that a medical bill remains unpaid by the workers' compensation insurer after 45 days or more from the date an accurately completed bill was submitted to the workers' compensation insurer. To qualify as a non-payment issue the insurer must have failed to reimburse for billed services, failed to issue an EOBR to explain reason for non-payment, failed to acknowledge receipt of the medical bill, and/or failed to file a form [DFS-F2-DWC-12](#) form with the Division.
- Q. How does the provider file a [non-payment complaint](#)?
- A. A provider can file a non-payment complaint 46 days or more from the date the workers' compensation insurer received the accurately completed medical bill when no notice of payment or disallowance is received. The complaint may be faxed to (850) 922-4475, emailed to workers.compmedservice@myfloridacfo.com or mailed to the Division of Workers' Compensation, Office of Medical Services at 200 East Gaines St.; Tallahassee, FL 32399-4232.

REIMBURSEMENT TOPICS”: BILLING AND REPORTING MEDICAL SERVICES AND TREATMENT

- Q.** Are there any time-frame requirements for submitting medical bills to a workers' compensation insurer?
- A.** No, there are no statutory time-frame requirements for submitting a medical bill to a workers' compensation insurer. However, the provider should submit a bill as soon as possible after the services are rendered. The sooner the medical bill is submitted to the insurer, the sooner the provider is reimbursed for the service(s) rendered and the insurer meets their requirement for timely payment of the bill. As the medical condition determines the injured employee's entitlement to continuing medical treatment, it also determines other benefits to which the injured employee is entitled, e.g. compensation payment benefits, retraining benefits, etc. Therefore, it is important that the insurer receive the necessary medical reports and bills quickly to ensure the injured employee receives appropriate benefits in a timely manner.
- Q.** What [billing forms](#) are used to bill rendered medical services and treatment?
- A.** Physician and other licensed practitioner services, including oral and maxillofacial services, are reported and billed on the form [DFS-F5-DWC-9](#) (CMS 1500); Medical Supplies and Drugs dispensed by pharmacies and durable medical equipment suppliers are reported and billed on the form [DFS-F5-DWC-10](#) (Statement of Charges for Drugs and Medical Equipment and Supplies Form); Dental services are reported and billed on the form [DFS-F5-DWC-11](#) (ADA Claims Form); Facility services (to include hospital, ASC, Nursing Homes, and Home Health Care) are reported on the form [DFS-F5-DWC-90 \(UB-04\)](#).
- Q.** Who is responsible for payment of services rendered to injured employee for a compensable injury?
- A.** The workers' compensation insurer is responsible for the payment of all authorized, medically necessary services.
- Q.** How is reimbursement for services determined?
- A.** Reimbursement is based on the policy in effect on the date of service for the specific provider type rendering the billed services. The Florida Workers' Compensation system has established maximum reimbursement allowances (MRAs) for each provider type eligible to render services under this program: physicians, recognized practitioners, pharmacies, hospitals, and Ambulatory Surgical Centers. Nursing Homes, Home Health Agencies, and durable medical equipment (DME) providers are reimbursed under a contractual agreement between the provider and the insurer at the time of authorization for the service.

- Q.** Is the health care provider required to submit medical records and reports with the medical bill as a condition of reimbursement?
- A.** The workers' compensation insurer may disallow reimbursement for services when the provider fails to submit the [DFS-F5-DWC-25](#) which documents the request for authorization of the billed services as required by rule. An insurer may also disallow reimbursement for services when the provider fails to submit those documents listed in the reimbursement manual(s) or other forms of documentation specifically requested by the insurer in writing at the time of authorization. Examples may be:
- Itemized statement
 - Operative reports for surgical procedures
 - Implant certification/documentation
 - DWC-25, when required by rule
 - Documentation to support medical necessity of care, services or treatment
 - Medication administration records
- Q.** May a provider require the workers' compensation insurer to reimburse an amount different from the maximum reimbursement allowance provided the applicable reimbursement manual?
- A.** A provider may be reimbursed an amount greater or lesser than the listed MRA if the provider and workers' compensation insurer enter into a written reimbursement contract.
- Q.** How long does a workers' compensation insurer have after the receipt of a medical bill to respond to the provider?
- A.** A workers' compensation insurer is required by statute to pay, disallow, or deny reimbursement of an accurately completed medical bill within 45 days of receipt. Additionally, the insurer shall provide written notification of the reimbursement decision (Explanation of Bill Review, EOBR) to the provider, pursuant to Rule 69L-7.602, F.A.C.
- Q.** When completing the Form DWC-9 for services provided by recognized health care practitioner services to an injured employee, what number is entered in Field 33b?
- A.** All treatment, care and attendance services are to be billed by the recognized health care provider who directly rendered the billable service. However, Rule 69L-7.602(4)(b)(3) [Special Billing Requirements](#) Section requires recognized practitioners who are salaried employees of an authorized treating physician to bill under the employing physician's alpha-numeric *Florida Department of Health* license number or unique license number format.
- Q.** If a procedure code is valid in the CPT code book but is *not* listed in the Division fee schedule, how do I get bill and get reimbursed?

- A. Valid CPT/HCPCS codes not listed in the current fee schedule are reimbursed as 'By Report' codes. Submit the medical documentation to the insurer for insurer pricing and reimbursement.

NOTICE OF DENIAL OF PAYMENT FOR AUTHORIZED OR EMERGENCY MEDICAL TREATMENT AND SERVICES

- Q. What happens if the workers' compensation insurer denies the payment of services previously authorized by either the employer or insurer, or rendered as emergency treatment at the request of the employer?
- A. If the provider bills for rendered services, authorized by the employer or workers' compensation insurer or rendered as emergency treatment, and the insurer determines that the condition for which the services were rendered is not covered under the Florida Workers' Compensation system, the insurer is responsible for reimbursing the provider for such services until the insurer issues a Notice of Denial to the provider and all interested parties on the [Form DFS-F2-DWC-12](#), informing the provider that further treatment is not authorized and is not reimbursable, s.440.20(4), F.S.

BILLING THE INJURED EMPLOYEE

- Q. Can a provider bill an injured employee or refer an injured employee to a collection agency for payment of the difference in what the provider charged and what the workers' compensation insurer reimbursed?
- A. An injured employee shall not be responsible for the payment of medical treatment for a compensable condition. Therefore, a provider may not bill or refer an injured employee to a collection agency for the payment of services unpaid by the workers' compensation insurer, [s.440.13\(14\)\(a\),\(c\), F.S.](#)
- Q. Under what conditions can a health care provider bill an injured employee for the payment for medical services and/or treatment?
- A. A provider may bill an injured employee the required \$10.00 co-payment for each office visit after the injured employee has reached MMI. The provider may also bill the injured employee for any care or treatment rendered for a non-related condition, a condition deemed non-compensable by the workers' compensation insurer or, or when the insurer applies apportionment to reimbursement, [s.440.13\(14\)\(c\),F.S.](#)

MONITORING HCP COMPLIANCE WITH ESTABLISHED POLICIES AND STANDARD OF CARE REQUIREMENTS

Q. Are providers required to follow any specific guidelines in the provision of medical treatment and services to injured employees?

A. Providers are required to follow the [Standards of Care](#) provisions in s. 440.13(16), F.S., when rendering medically necessary treatment and care to injured employees.

Q. How are rendered services monitored to ensure compliance with applicable statutory and rule requirements?

A. All medical billing claims submitted to a workers' compensation insurer for reimbursement are filed with the Division by the workers' compensation insurer. The Division monitors the medical claims data to ensure providers are not in violation of applicable administrative rules related to the standards of care and the billing and reporting of services.

The Division may also conduct a medical record or file review to validate the accuracy of the medical claims data filed by workers compensation insurers.

Q. What are health care violations?

A. A HCP [violation](#) is a provider's non-compliance with the requirements of Chapter 440, F.S. and Division rules, which include: improper billing pursuant to Rule 69L-7.602, Florida Administrative Code; failing to submit medical records and reports pursuant to s. 440.13(4)(a) and (c), F.S.; failing to refund an overpayment of reimbursement, pursuant to s. 440.13(11)(a), F.S.; collecting or receiving payment from an injured employee in violation of s. 440.13(14)(a), F.S.; or failing to follow the standards of care, pursuant to s. 440.13(16), F.S., including overutilization of services.

Q. Who can file a HCP violation referral or complaint?

A. A workers' compensation insurer can file, via email or regular mail, a HCP violation referral or an employee, a Division employee or citizen can send a HCP violations complaint to the Division at: workers.compmedservice@myfloridacfo.com or Division of Workers' Compensation, Office of Medical Services, 200 East Gaines Street, Tallahassee, FL 32399-4232.

Q. What are the consequences for non-compliance with established administrative rules and policies?

A. The Division may impose [administrative penalties and sanctions](#) for [violations](#) of Chapter 440, F.S. and applicable rules. These actions are pursuant to sections 440.13(8), (11), and (13), F.S., and may include but are not limited to:

- An order of the department barring the provider from payment under this chapter;
- Deauthorization of care under review;

- Denial of payment for care rendered in the future;
- Decertification of a health care provider certified as an expert medical advisor under subsection (9)
- An administrative fine assessed by the department in an amount not to exceed \$5,000 per instance of overutilization or violation;
- Notification of and review by the appropriate licensing authority pursuant to s. 440.106(3), F.S.; and
- Removal of name from Division provider database.