DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

69L-56 ELECTRONIC DATA INTERCHANGE (EDI) REQUIREMENTS FOR PROOF OF COVERAGE AND CLAIMS (NON-MEDICAL)

RULE NO.: RULE TITLE:

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69L-56.001 Forms and Instructions.

The following forms are incorporated herein by reference and adopted for use in filing Proof of Coverage (POC) and Claims (non-medical) Electronic Data Interchange (EDI) transactions to the Division. All of the forms may be obtained from the Division of Workers' Compensation at its website, http://www.myfloridacfo.com/WC/edi_clms.html

(1) DFS-F5-DWC-EDI-1, "EDI Trading Partner Profile" (1/01/2008).
(2) DFS-F5-DWC-EDI-2, "EDI Trading Partner Insurer/Claim Administrator ID List" (10/01/2006).
(3) DFS-F5-DWC-EDI-2A, "EDI Trading Partner Claim Administrator Address List" (10/01/2006).
(4) DFS-F5-DWC-EDI-3, "EDI Transmission Profile-Sender's Specifications" (10/01/2006).
(5) DFS-F5-DWC-EDI-4, "Secure Socket Layer (SSL)/File Transfer Protocol (FTP) Instructions" (1/01/2008).

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 3-5-02, Formerly 38F-56.001, 4L-56.001, Amended 5-29-05, 1-7-07, 5-17-09.

69L-56.002 Definitions.

Unless otherwise defined in this section, definitions of data elements and terms used in this rule are defined in the Data Dictionary located in Section 6 of the "IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition", and in the Data Dictionary located in Section 6 of the "IAIABC Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition", and in the IAIABC "Glossary", October 2008, and in the IAIABC Claims EDI R3 "Supplement" January 2009 and the IAIABC POC EDI R2.1 "Supplement",

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June 2007, all of which are incorporated herein by reference. Copies of the IAIABC guides, supplements, and glossary may be obtained from the IAIABC's website at, http://www.iaiabc.org, under "EDI" link, then "Implementation Guides" link.

When used in this chapter, the following terms have the following meanings:

(1) "Acknowledge" or "acknowledgement" means a response provided by the Division to communicate the acceptance or rejection of an electronic transaction sent to the Division. An acknowledgement returned by the Division will reflect the assignment of an Application Acknowledgment Code of "TA" (Transaction Accepted) if the transaction was accepted by the Division, or "TR" (Transaction Rejected) if the transaction was rejected by the Division. If a transaction was assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) the date the transaction was received by the Division will be used in determining whether an electronic form was timely filed with the Division.

(2) "Award/Order Date" means the date an award, stipulated agreement, advance, lump sum settlement order, or order approving attorney fees for a lump sum settlement was signed by a Judge of Compensation Claims.

(3) "Average Wage" means the employee's average weekly wage as determined in Section 440.14, FS.

(4) "Batch" means a set of records containing one header record, one or more detailed transactions, and one trailer record.

(5) "Became Medical Only Case" means a work-related injury or illness that was initially reported to the Division in error as a "Lost Time/Indemnity Case" or "Medical Only to Lost Time Case" and subsequently determined to be a "Medical Only Case" where FROI MTC 01 is being filed to cancel the claim. A "Became Medical Only Case" is represented by Claim Type Code "B" (Became Medical Only) and is only allowed for FROI MTC 01 (Cancel) filings.

(6) "Benefit Payment Issue Date" reported for MTC "IP" (Initial Payment), "AP" (Acquired Payment), "PY" (Payment), and "RB" (Reinstatement of Benefits) means the date payment of a specific indemnity benefit corresponding to the MTC being reported left the control of the claim administrator (or the claim administrator's legal representative if delivery is made by the legal representative) for delivery to the employee or the employee's representative, whether by U.S. Postal Service or other delivery service, hand delivery, or transfer of electronic funds. "Benefit Payment Issue Date" for MTC "S1-8" (Suspension reasons) means the date the last indemnity check prior to the suspension of benefits left the control of the claim administrator (or the claim administrator's legal representative if delivery is made by the legal representative) for the delivery to the employee or the employee's representative, whether by U.S. Postal Service or other delivery service, hand delivery, or transfer of electronic funds. The Benefit Payment Issue Date shall not be sent as the date the check is requested, created, or issued in the claim administrator's system unless the check leaves the control of the claim administrator the same day it is requested, created, or issued for delivery to the employee or the employee's representative.

(7) "Business day" means a day on which normal business is conducted by the State of Florida and excludes observed holidays as set out in Section 110.117(1), F.S. (see also State Holidays under http://dms.myflorida.com/human_resource_support/human_re source_management/for_state_hr_practitioners).

(8) "Calculated Weekly Compensation Amount" means 66 2/3 % of the employee's average weekly wage pursuant to Section 440.14, F.S., subject to the minimum and maximum amounts set out in Section 440.12, F.S., (a/k/a, the statutory compensation rate).

(9) "Cancellation/Non-Renewal Effective Date" means the Transaction Set Type Effective Date as defined in the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07, for a cancellation or non-renewal of any workers' compensation insurance policy, contract of insurance or renewal; and shall be effective at 12:01 a.m. on the Transaction Set Type Effective Date reported to the Division, or the Cancellation/Non-Renewal Effective Date derived by the Division as determined in Rule 69L-56.200, F.A.C.

(10) "Catastrophic Event" means the occurrence of an event outside the control of an insurer, claim administrator, or third party vendor, such as a telecommunications failure due to a natural disaster or act of terrorism

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(including but not limited to cyber terrorism), in which recovery time will prevent an insurer, claim administrator, or third party vendor from meeting the filing requirements of Chapter 440, F.S., and this rule. Programming errors, systems malfunctions, or electronic data interchange failures that are not the direct result of a catastrophic event are not considered to be a catastrophic event as defined in this rule.

(11) "Claim Administrator" means any insurer, service company/third party administrator, self-serviced self-insured employer or fund, or managing general agent, responsible for adjusting workers' compensation claims, that is electronically sending its data directly to the Division.

(12) "Claim Administrator Primary Address", "Claim Administrator Secondary Address", "Claim Administrator City", "Claim Administrator State Code", and "Claim Administrator Postal Code" comprise the address associated with the physical location of the claims office at which a workers' compensation claim is being adjusted.

(13) "Claim Administrator Alternate Postal Code" means the zip code associated with the Claim Administrator's mailing address established for receiving mail on behalf of the claims office at which a workers' compensation claim is being adjusted.

(14) "Claim Type Code" means a code representing the current classification of the claim as either a "Lost Time /Indemnity Case" (Claim Type Code "I"), "Medical Only to Lost Time Case" (Claim Type Code "L"), "Became Medical Only Case" (Claim Type Code "B") or "Medical Only Case" (Claim Type Code "M").

(15) "Client company" is as defined in Section 468.520(6), F.S.

(16) "Date of Maximum Medical Improvement" (MMI) means the date on which maximum medical improvement has been achieved with respect to all compensable medical or psychiatric conditions caused by a compensable injury or disease (i.e., overall MMI).

(17) "Date Claim Administrator Had Knowledge of Lost Time" means the date the claim administrator was notified or became aware that the employee was disabled for eight (8) or more days and was entitled to indemnity benefits. If the claim administrator acquires a claim from another claim administrator and is filing the Electronic First Report of Injury or Illness with the Division, the "Date Claim Administrator Had Knowledge of Lost Time" shall be the date the acquiring claim administrator had knowledge of the employee's 8th day of disability.

(18) "Days" means calendar days, unless otherwise noted.

(19) "Denied Case" means a "Full Denial" or "Partial Denial" case for which all indemnity benefits are initially denied by the claim administrator.

(20) "Department" means the Department of Financial Services.

(21) "Division" means the Division of Workers' Compensation.

(22) "Electronic Data Interchange" (EDI) means a computer-to-computer exchange of business transactions in a standardized electronic format.

(23) "Electronic Form Equivalent" means information sent in Division-approved electronic formats as specified in this rule, instead of otherwise required paper documents. Electronic form equivalents do not include information sent by facsimile, file data attached to electronic mail, or computer-generated paper forms.

(24) "Employee leasing" is as defined in Section 468.520(4), F.S.

(25) "Employee leasing company" is as defined in Section 468.520(5), F.S.

(26) "Employee Leasing Policy Identification Code" is a code which identifies a policy written as an employee leasing policy, and the type of leasing operation.

(27) "Employer Paid Salary in Lieu of Compensation" means the employer paid the employee salary, wages, or other remuneration for a period of disability for which the insurer would have otherwise been obligated to pay indemnity benefits. This does not include the waiting week if the employee was not disabled for 22 or more days.

(28) "File" or "Filed" means a transaction has been received by the Division and passes quality and structural edits and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted).

(29) "FROI" means the First Report of Injury Record Layout adopted by the IAIABC as a Claims EDI Release 3 standard, and is comprised of the First Report of Injury Record identified by Transaction Set ID "148" paired with

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the First Report of Injury Companion Record identified by Transaction Set ID "R21". The "FROI" record layout (148/R21) is located in the Technical Documentation, Section 2, in the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgement Detail, Header, & Trailer Records, Release 3, January 1, 2009, which is incorporated herein by reference. A copy of the guide may be obtained from the IAIABC's website at http://www.iaiabc.org, under "EDI" link, then "Implementation Guides" link.

(30) "Full Denial" means any case for which the claim administrator has denied liability for all workers' compensation benefits (i.e., both indemnity and medical benefits). A "Full Denial" is represented by a FROI or SROI MTC 04 (Denial).

(31) "Gross Weekly Amount" means the weekly amount payable for a specific Benefit Type and excludes the application of any Benefit Adjustments or Benefit Credits. The Gross Weekly Amount is usually equal to the Calculated Weekly Compensation Amount (a/k/a/ statutory compensation rate) except when the weekly rate for a Benefit Type is paid as a percentage of either the Calculated Weekly Compensation Amount (Comp Rate), Average Wage, or average temporary total disability benefits, such as for Permanent Total Supplemental Benefits, Death Benefits, and Impairment Income Benefits.

(32) "Header Record" means the first record of a batch. The header record shall uniquely identify a sender, as well as the date and time a batch is prepared, and the transaction set within the batch.

(33) "IAIABC" means the International Association of Industrial Accident Boards and Commissions (www.iaiabc.org), which is a professional trade association comprised of state workers' compensation regulators and insurance representatives.

(34) "Industry Code" means the 5 or 6-digit code that represents the nature of the employer's business as published in the North American Industry Classification System (NAICS) 2007 Edition, hereby incorporated by reference. NAICS code information may be obtained by contacting the NAICS Association, 341 East James Circle, Sandy, Utah, 84070, or from the NAICS website at www.naics.com.

(35) "Initial Date of Lost Time" means the employee's eighth (8th) day of disability, i.e., the first day on which the employee sustains disability as defined in Section 440.02, F.S., after fulfilling the seven (7) day waiting week requirement in Section 440.12, F.S. The Initial Date of Lost Time does not mean the "Initial Date Disability Began".

(36) "Initial Disposition" means the first action taken by the claim administrator following its knowledge of an injury to accept or deny compensability of the claim and pay or deny benefits, including payment or denial of both indemnity and medical benefits, or denial of indemnity benefits only.

(37) "Insurer" means an insurer as defined in Section 440.02, F.S.

(38) "Insurer Code #" means the Division-assigned number for the insurer bearing the financial risk of the claim.

(39) "Jurisdiction Designee Received Date" means the date on which a third party vendor received Proof of Coverage data from an insurer that is not submitting their electronic Proof of Coverage data directly with the Division. This date shall be used in place of the date the Division received electronic Proof of Coverage data for purposes of calculating the effective date of the cancellation or non-renewal, and timely filings of electronic Proof of Coverage data.

(40) "Knowledge" or "Notification" means an entity's earliest receipt of information, including by mail, telephone, facsimile, direct personal contact, or electronic submission.

(41) "Lost Time/Indemnity Case" means a work-related injury or illness which causes the employee to be disabled for more than 7 calendar days, or for which indemnity benefits have been paid. A Lost Time/Indemnity Case shall also include: A case involving a compensable volunteer pursuant to Section 440.02(15)(d)6., F.S., where no indemnity benefits will be paid, but where the employee is disabled for more than 7 calendar days; a compensable death case pursuant to Section 440.16, F.S., for which there are no known or confirmed dependents; a case where a compensable injury results in disability of more than 7 calendar days where the "Employer Paid Salary in Lieu of Compensation" as defined in this section; a case for which indemnity benefits were paid prior to the date the claim administrator learned of a change in jurisdiction and filed SROI MTC S8 (Suspension, Jurisdiction Change); and a case where indemnity benefits were paid but subsequently suspended because the employee could

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not be located and the claim administrator filed SROI MTC S6 (Suspension, Claimant's Whereabouts Unknown). The first 7 calendar days of disability do not have to occur consecutively, but are determined on a cumulative basis and can occur over a period of time. A "Lost Time/Indemnity Case" is represented by Claim Type Code "I" (Indemnity).

(42) "Maintenance Type Code" (MTC) defines the specific purpose of individual claims transactions within the batch being sent, i.e., a code that represents the type of filing being sent electronically (For example: MTC IP = initial payment, MTC 04 = Total or Full Denial). MTC's and data elements required by this rule may not exactly match paper claim forms and associated data reporting requirements set out in Rule Chapter 69L-3, F.A.C.

(43) "Manual Classification Code" means the 4-digit code assigned by the National Council on Compensation Insurance (NCCI) for the particular occupation of the injured employee as documented in the NCCI Scopes™ Manual 2009 Edition, which is hereby incorporated by reference. A listing of Manual Classification Codes may be obtained by contacting NCCI's Customer Service Center at 1(800)622-4123.

(44) "Medical Only Case" means a work-related injury or illness which requires medical treatment for which charges will be incurred, but which does not cause the employee to be disabled for more than 7 calendar days. A "Medical Only Case" is represented by Claim Type "M" (Medical Only) and is limited to being reported on MTC 04 and PD filings where the claim was initially accepted as a Medical Only Case prior to the denial of indemnity benefits.

(45) "Medical Only to Lost Time Case" means a work-related injury or illness which initially does not result in disability of more than 7 calendar days, but later results in disability of more than 7 days, where disability is either delayed and does not immediately follow the accident, or where one or more broken periods of disability occur within the first 7 days after disability has commenced and the combined disability periods eventually total more than 7 days. A "Medical Only to Lost Time Case" includes a case for which Impairment Income Benefits are the first and only indemnity benefits paid, or for which the initial payment of indemnity benefits is made in a lump sum for an award, advance, stipulated agreement or settlement. A "Medical Only to Lost Time Case" is represented by Claim Type Code "L" (Became Lost Time/Indemnity).

(46) "Net Weekly Amount" means the weekly amount paid for an indemnity benefit such as temporary total benefits, impairment income benefits, etc., inclusive of any Benefit Adjustments or Benefit Credits being applied to the benefit type. The Net Weekly Amount equals the "Gross Weekly Amount" where no adjustments or credits are applied.

(47) "Partial Denial" means a case where compensability is accepted but the claim administrator initially denies all indemnity benefits and only medical benefits will be paid; Partial Denial also means a case where a specific indemnity benefit(s) was previously paid but subsequently denied, either in whole or in part. A "Partial Denial" is represented by a SROI MTC "PD".

(48) "Payment Issue Date" for MTC "IP"(Initial Payment), and "PY" (Payment) means the date payment of a specific indemnity benefit corresponding to the MTC being reported left the control of the claim administrator (or the claim administrator's legal representative if delivery is made by the legal representative) for delivery to the employee or the employee's representative, whether by U.S. Postal Service or other delivery service, hand delivery, or transfer of electronic funds. The Payment Issue Date shall not be sent as the date the check is requested, created, or issued in the claim administrator's system unless the check leaves the control of the claim administrator the same day it is requested, created, or issued for delivery to the employee or the employee's representative.

(49) "Permanent Impairment Percentage" means "Permanent Impairment" as defined in Section 440.02, F.S.

(50) "Sender" means one of the following entities sending electronic filings to the Division:

(a) Claim Administrator,

(b) Insurer, or

(c) Third Party Vendor (Proof of Coverage only).

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For Claims EDI filing purposes, "sender" does not include an entity acting as an intermediary for sending transmissions to the Division on behalf of an insurer or claim administrator where the sender is not the insurer or claim administrator handling the claim.

(51) "SROI" means the Subsequent Report of Injury Record Layout adopted by the IAIABC as a Claims EDI Release 3 standard, and includes the Subsequent Report Record identified by Transaction Set "A49" paired with the Subsequent Report Companion Record identified with Transaction Set ID "R22". The "SROI" record layout (A49/R22) is located in the Technical Documentation, Section 2, in the IAIABC EDI Implementation Guide for First, Subsequent, Acknowledgement Detail, Header, & Trailer Records, Release 3, January 1, 2009, and Supplement, which is incorporated herein by reference. A copy of the guide may be obtained from the IAIABC's website at http://www.iaiabc.org, under the "EDI" link, then "Implementation Guides" link.

(52) "Third Party Vendor" means an entity acting as a submission agent or vendor on behalf of an insurer, service company or third party administrator, which has been authorized to electronically send required data to the Division.

(53) "Trading Partner" means an entity approved by the Division in accordance with Rules 69L-56.110, 69L-56.310 and 69L-56.320, F.A.C., to exchange data electronically with the Division.

(54) "Trailer Record" means the last record that designates the end of a batch of transactions. It shall provide a count of transactions contained within the batch, not including the header and trailer transactions.

(55) "Transaction" is one or more records within a batch which communicates information representing an electronic form equivalent.

(56) "Transaction Accepted Code TA" means an Application Acknowledgement Code returned by the Division on the acknowledgement transaction to represent that a transaction was received by the Division and passed required edits.

(57) "Transaction Rejected Code TR" means an Application Acknowledgement Code returned by the Division on the acknowledgement transaction to represent that a transaction was received by the Division and did not pass required edits.

(58) "Transmission" consists of one or more batches sent to or received by the Division or a trading partner.

(59) "Triplicate Code" is a series of three two-digit numeric codes that define the specific purpose of individual records in a Proof of Coverage transmission, i.e., new policy, renewal, endorsement, cancellation or non-renewal. It is a combination of the Transaction Set Purpose Code, Transaction Set Type Code and Transaction Set Reason Code as defined in the Data Dictionary, Section 6 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/2007 Edition, which is incorporated herein by reference. A copy of the guide may be found at http://www.iaiabc.org, under "EDI" link, then "Implementation Guides" link.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 3-5-02, Formerly 38F-56.002, 4L-56.002, Amended 5-29-05, 1-7-07, 5-17-09.

69L-56.100 Proof of Coverage (POC) Electronic Reporting Requirements.

(1) Effective March 1, 2002, every insurer authorized to insure employers in the State of Florida, except for individual self-insurers approved under Section 440.38, F.S., shall file policy information electronically to the Division rather than by filing on paper forms previously required.

Every insurer shall send to the Division by electronic data interchange electronic policy information for Certificates of Insurance, Endorsements, Reinstatements, Cancellations and Non-Renewals pursuant to the filing time periods in Rule 69L-56.210, F.A.C., of this chapter. Such policy information shall be sent in accordance with the "EDI Trading Partner Requirements" set forth in Sections 2 through 6 of the Florida Division of Workers' Compensation Proof of Coverage Electronic Data Interchange (EDI) Implementation Manual, 1/01/2009, which is incorporated herein by reference. A copy of the manual may be obtained from the Division of Workers' Compensation at its website,

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http://www.myfloridacfo.com/WC/edi_poc.html or by sending a request to the Division of Workers' Compensation, Bureau of Data Quality and Collection, 200 East Gaines Street, Tallahassee, Florida 32399-4226. The Division will not accept an electronic transaction that fails to comply with the "EDI Trading Partner Requirements" in Sections 2 through 6 in this manual. The insurer shall send electronic transmissions either directly to the Division or through a third party vendor.

(2) On or before April 2, 2007, all electronic form equivalents of Proof of Coverage data shall be sent in the Proof of Coverage formats adopted by the IAIABC and located in Section 2 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/2007 Edition.

(3)(a) At least one (1) business day before the insurer or third party vendor sends its first transmission to the Division, the insurer or third party vendor shall send to the Division in an email addressed to poc.edi@myfloridacfo.com, their profile information using the following forms adopted in Rule 69L-56.001, F.A.C.:

1. "EDI Trading Partner Profile," DFS-F5-DWC-EDI-1 (1/01/2008), and
2. "EDI Trading Partner Insurer/Claim Administrator ID List", DFS-F5-DWC-EDI-2 (10/01/2006), and
3. "EDI Transmission Profile – Sender's Specifications," DFS-F5-DWC-EDI-3 (10/01/2006).

(b) The insurer or third party vendor shall report changes to its profile information to the Division at least one (1) business day before sending transactions containing new profile-related information. The insurer or third party vendor shall report the new profile information by emailing a revised "EDI Trading Partner Profile", DFS-F5-DWC-EDI-1 (1/01/2008), and if applicable, the "EDI Trading Partner Insurer/Claim Administrator ID List", DFS-F5-DWC-EDI-2 (10/01/2006), and if applicable, the "EDI Transmission Profile – Sender's Specifications", DFS-F5-DWC-EDI-3 (10/01/2006) to the Division at poc.edi@myfloridacfo.com.

(c) If the insurer suspends the use of a third party vendor and begins sending its electronic Proof of Coverage data directly to the Division, the insurer shall, at least one (1) business day prior to the effective date of this change, email a revised "EDI Transmission Profile – Sender's Specifications," DFS-F5-DWC-EDI-3 (10/01/2006), to the Division at poc.edi@myfloridacfo.com.

(d) If the insurer changes third party vendors, the insurer shall, at least one (1) business day prior to the effective date of the change, send an email to the Division at poc.edi@myfloridacfo.com to report the name of the new vendor and effective date on which POC transactions will be sent by the new vendor.

(e) Insurers or third party vendors that experience a catastrophic event resulting in the insurer's failure to meet the filing requirements of this rule, shall submit a written or electronic request to the Division for approval to submit required electronic form equivalents in an alternative filing timeline. The request shall be sent to the Division within 15 business days after the catastrophic event. The request shall contain a detailed explanation of the nature of the event, date of occurrence, and measures being taken to resume electronic submission. The insurer or third party vendor shall also provide an estimated date by which electronic submission of affected EDI filings will be resumed. Approval to submit in an alternative filing timeline shall be granted by the Division if a catastrophic event prevents electronic submission. The approval must be obtained from the Division's Bureau of Data Quality and Collection, 200 E. Gaines Street, Tallahassee, Florida 32399-4226, or via email at poc.edi@myfloridacfo.com.

Rulemaking Authority 440.185(7), 440.591, 440.593(5) FS. Law Implemented 440.185(7), 440.593 FS. History–New 3-5-02, Formerly 38F-56.100, 4L-56.100, Amended 5-29-05, 1-7-07, 5-17-09.

69L-56.110 Technical Requirements for POC EDI Transmissions.

(1) In order to send Proof of Coverage data electronically to the Division, the insurer or third party vendor shall complete the testing requirements set forth in Section 1 of the Florida Division of Workers' Compensation Proof of Coverage Electronic Data Interchange (EDI) Implementation Manual, 1/01/09. Each transmission for Test or Production purposes shall be in the PC1-Insured Record format and PC2-Employer Record format located in Section

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2 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition and Supplement.

(2) Each transmission shall contain the following as set forth in Section 2 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition:

(a) Header Record.

(b) One or more records – PC1, PC2 (See "Transaction Overview, Sub Type Code" column located in Section 4 of the guide).

(c) Trailer Record.

(3) Header records shall include the following information:

(a) Receiver FEIN for the State of Florida: 59-6001874.

(b) "Receiver Postal Code" for the State of Florida: 323994226

(c) Sender Identifier. The Sender Identifier (Sender ID) shall consist of the insurer's or third party vendor's FEIN and Postal Code as reported on Form DFS-F5-DWC-EDI-3 (10/01/2006), EDI Transmission Profile-Sender's Specifications.

(d) "Sender Postal Code" as indicated on DWC Form EDI-3 "EDI Transmission Profile-Sender's Specifications."

(4) POC EDI transmissions may be sent on a daily basis, and shall be sent via secured File Transfer Protocol (FTP). Effective June 1, 2005, electronic transmissions of Proof of Coverage data required pursuant to this rule, shall be sent to the Division using Secure Socket Layer/File Transfer Protocol (SSL/FTP) in accordance with instructions on Form DFS-F5-DWC-EDI-4 (1/01/2008).

(5) Transmissions received on or before 9:00 p.m., Eastern Standard Time, shall be processed by the Division the same day the transmission was sent to the Division and acknowledged by the Division the next business day. Transmissions received after 9:00 p.m. through 11:59 p.m., Eastern Standard Time, shall be processed by the Division the following day and acknowledged by the Division the next day after the transmission is processed.

(6) Transmissions shall be sent using the flat file PC1 and PC2 formats located in Section 2 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition and Supplement.

(7) For test transmissions, the "Test-Production Indicator" in the Header record shall be set to "T." Beginning with authorized production transmissions, the "Test-Production Indicator" shall be set to "P."

(8) All insurers or third party vendors shall have the capability to receive and process the Division's POC EDI Acknowledgement Transaction (AKP), described in Section 2 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition and Supplement. The Division will also send, when applicable, a re-acknowledgment transaction (ACR) to identify an EDI filing previously acknowledged with Application Acknowledgement Code "TR" (Transaction Rejected) due to improper processing, that was subsequently re-processed by the Division and re-assigned an Application Acknowledgement Code of "TA" (Transaction Accepted). The claim administrator shall have the option of processing re-acknowledgement transactions.

(9) The definitions established in Section 6 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition and Supplement, shall be utilized when reporting data elements to the Division.

(10) The insurer or third party vendor shall send the PC1 and PC2 transactions required in Rule 69L-56.210, F.A.C., in accordance with the information appearing in the "Sub Type Code" column in the "Proof of Coverage Transaction Overview" document, located in Section 4 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition. If the PC2 record is required and is rejected by the Division, both the PC1 and PC2 records shall be re-sent together in the

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same transmission. The Division will not “hold” a PC1 record in anticipation of the return of a corrected corresponding PC2 record.

(11) The insurer or third party vendor’s business and technical contacts shall have e-mail system capabilities that support Word, Excel, or PDF attachments from the Division of at least 2 Megabytes.

(12) The insurer or third party vendor shall utilize anti-virus software to screen out and clean any viruses on all electronic transmissions prior to sending transmissions to the Division. The insurer or third party vendor shall maintain the anti-virus software with the most recent anti-virus update files from the software provider. If the insurer or third party vendor sends a transmission that contains a virus which prevents the Division from processing the transmission, the transmission will not be considered as having been received by the Division.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 3-5-02, Formerly 38F-56.110, 4L-56.110, Amended 5-29-05, 1-7-07, 5-17-09.

69L-56.200 Policy Cancellation or Non-Renewal Requirements.

(1) Except for cancellation for nonpayment of premium or failure to pay deductible, or cancellation or non-renewal at the request of the insured, an insurer shall not cancel or non-renew any workers’ compensation insurance policy, contract of insurance, or renewal until at least 30 days have elapsed after the insurer has electronically filed a cancellation or non-renewal with the Division, either directly or through a third party vendor. When an insurer files an electronic cancellation or non-renewal directly with the Division for any reason other than non-payment of premium or failure to pay deductible or when cancellation or non-renewal is requested by the insured, the 30-day notice period (Cancellation/Non-Renewal Effective Date) shall be calculated from the first day following the date on which the electronic cancellation or non-renewal was filed with the Division. If the insurer files an electronic cancellation or non-renewal through a third party vendor for any reason other than non-payment of premium or failure to pay deductible, or when cancellation or non-renewal is requested by the insured, the 30-day notice period (Cancellation/Non-Renewal Effective Date) shall be calculated from the first day following the “Jurisdiction Designee Received Date”.

(2)(a) For any workers’ compensation insurance policy, contract of insurance, or renewal with a policy effective date prior to October 1, 2003, an insurer shall not cancel or non-renew the policy for non-payment of premium or failure to pay deductible until and unless 30 days have elapsed after the insurer has electronically filed a cancellation or non-renewal with the Division, either directly or through a third party vendor. When an insurer files an electronic cancellation or non-renewal directly with the Division, the 30-day notice period (Cancellation/Non-Renewal Effective Date) shall be calculated from the first day following the date on which the electronic cancellation or non-renewal was filed with the Division. If the insurer files an electronic cancellation or non-renewal through a third party vendor, the 30-day notice period (Cancellation/Non-Renewal Effective Date) shall be calculated from the first day following the “Jurisdiction Designee Received Date”.

(b) For any workers’ compensation insurance policy, contract of insurance, or renewal with a policy effective date on or after October 1, 2003, an insurer shall not cancel or non-renew the policy for non-payment of premium or failure to pay deductible until and unless the insurer has mailed notification of the cancellation or non-renewal to the employer at least 10 days prior to the effective date of the cancellation or non-renewal. Notification to the Division is not required to cancel or non-renew a workers' compensation insurance policy, contract of insurance, or renewal for non-payment of premium or failure to pay deductible. However, the insurer shall advise the Division of the cancellation or non-renewal due to non-payment of premium or failure to pay deductible in accordance with the electronic filing time periods for policy information set out in subsections 69L-56.210(5) and (6), F.A.C.

(3) If an insured requests cancellation or non-renewal of any workers’ compensation insurance policy, contract of insurance or renewal, the cancellation or non-renewal shall be effective on the date the insurer sends the cancellation or non-renewal to the insured. Notification to the Division is not required to cancel or non-renew a workers’ compensation insurance policy, contract of insurance, or renewal when cancellation or non-renewal is

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requested by the insured. However, the insurer shall advise the Division of the Cancellation/Non-Renewal Effective Date requested by the insured in accordance with the electronic filing time periods for policy information set out in subsection 69L-56.210(7), F.A.C.

(4) If a policy has been re-written by the same insurer for the same employer with the same effective date and has been electronically filed with the Division, the earlier policy may be cancelled by the insurer the same day the earlier policy became effective. The insurer shall electronically file a cancellation or non-renewal directly with the Division or through a third party vendor, and serve a copy of the notice of cancellation or non-renewal upon the employer in person or by mail, stating therein the reason for such cancellation or non-renewal.

Rulemaking Authority 440.185(7), 440.42(3), 440.591, 440.593(5), 627.4133(4) FS. Law Implemented 440.185(7), 440.42(3), 440.593, 627.4133(4), FS. History–New 5-29-05, Amended 1-7-07, 5-17-09.

69L-56.205 Policy Reporting Requirements for Employee Leasing Companies.

For any workers' compensation insurance policy, contract of insurance or renewal written for an employee leasing company or clients of an employee leasing company, with a policy effective date on or after October 1, 2009, the insurer shall electronically file any workers' compensation insurance policy, contract of insurance, or renewal pursuant to the requirements set forth in Rule 69L-56.210, F.A.C., and report one of the Employee Leasing Policy Idenitification Codes shown below from Section 6 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition and Supplement:

(1) Employee Leasing Policy Identification Code (2) – identifies an Employee leasing policy for leased workers of multiple client companies. The non-leased workers of the employee leasing company may also be covered under this policy. The insured name reported shall be the name of the employee leasing company and shall be reported on the IAIABC POC Release 2.1 Insured Record (PC1). The client names reported shall be the legal business name of each client company, and shall not be preceded with the name of the Employee leasing company and shall be reported on the IAIABC POC Release 2.1 Employer Record(s) (PC2).

(a) If an employee leasing company policy is reported with the Employee Leasing Policy Identification Code (2), an employee leasing policy for leased workers of multiple client companies, the Insurer shall report the addition of client companies to the policy in accordance with subsection 69L-56.210(2), F.A.C., using Triplicate Codes 00-31-54, 00-31-87 or 00-31-86.

(b) If an Employee leasing company policy is reported with Employee Leasing Policy Identification Code (2), an employee leasing policy for leased workers of multiple client companies, the Insurer shall report the deletion of client companies from the policy in accordance with subsection 69L-56.210(2), F.A.C., using Triplicate Codes 00-33-56 or 00-33-87.

(c) Cancellation or non-renewal of the entire policy for Employee Leasing Policy Identification Code (2) shall be reported in accordance with Rule 69L-56.200, F.A.C.

(2) Employee Leasing Policy Identification Code (3) – identifies an employee leasing policy for non-leased workers of the Employee leasing company. The insured name reported shall be the legal business name of the Employee leasing company and shall be reported on the IAIABC POC Release 2.1 Insured Record (PC1). Cancellation or non-renewal of a policy for Employee Leasing Policy Identification Code (3) shall be reported in accordance with Rule 69L-56.200, F.A.C.

(3) Employee Leasing Policy Identification Code (4) – identifies a client company policy for leased workers of the client company. The insured name reported shall be the name of the Client company and shall not be preceded with the name of the Employee leasing company and shall be reported on the IAIABC POC Release 2.1 Insured Record (PC1).

Cancellation or non-renewal of a policy for the Employee Leasing Policy Identification Code (4) shall be reported in accordance with Rule 69L-56.200, F.A.C.

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(4) Employee Leasing Policy Identification Code (5) – identifies an Employee leasing policy for leased workers of a single client company. The insured name reported shall be the name of the Employee leasing company and shall be reported on the IAIABC POC Release 2.1 Insured Record (PC1). The client name reported shall be the legal business name of the client company, and shall not be preceded with the name of the Employee leasing company, and shall be reported on the IAIABC POC Release 2.1 Employer Record(s) (PC2).
Cancellation or non-renewal of a policy for Employee Leasing Policy Identification Code (5) shall be reported in accordance with Rule 69L-56.200, F.A.C.

Rulemaking Authority 440.185(7), 440.42(3), 440.591, 440.593(5) FS. Law Implemented 440.185(7), 440.42(3), 440.593 FS. History–New 5-17-09.

69L-56.210 Time Periods for Filing Electronic Policy Information.
Pursuant to Section 440.593(1), F.S., the Division may establish different deadlines for filing required reports electronically than are otherwise required when reporting information by other means. Accordingly, notwithstanding the deadlines for filing policy information by other means as set forth in Section 440.185(7), F.S., an insurer, other than an individual self-insurer approved under Section 440.38, F.S., must electronically file the following information in accordance with the provisions of this rule, and shall have received an Application Acknowledgement Code of "TA" (Transaction Accepted) by the Division within the following deadlines:

(1) No later than thirty days after the effective date of any workers' compensation insurance policy, contract of insurance, or renewal, every insurer shall send the electronic Certificate of Insurance.

(2) No later than thirty days after the issue date of each endorsement to any workers' compensation insurance policy, contract of insurance, or renewal, every insurer shall send the electronic Notice of Endorsement.

(3) No later than thirty days after the effective date of each reinstatement of a cancelled workers' compensation insurance policy, contract of insurance, or renewal, every insurer shall send the electronic Notice of Reinstatement.

(4) No later than thirty days prior to the cancellation or non-renewal of any workers' compensation insurance policy, contract of insurance, or renewal, other than a cancellation for non-payment of premium or failure to pay deductible or when cancellation or non-renewal is requested by the insured, every insurer shall send the electronic cancellation or non-renewal.

(5) No later than thirty days prior to the cancellation of any workers' compensation insurance policy, contract of insurance, or renewal with a policy effective date prior to October 1, 2003, that is being cancelled for non-payment of premium or failure to pay deductible, every insurer shall send the electronic cancellation represented by Triplicate Codes "00-41-59", "00-41-69" and "00-60-59".

(6) No later than ten days prior to the cancellation of any workers' compensation insurance policy, contract of insurance, or renewal with a policy effective date on or after October 1, 2003, that is being cancelled for non-payment of premium or failure to pay deductible, every insurer shall send the electronic cancellation represented by Triplicate Codes "00-41-59", "00-41-69" and "00-60-59".

(7) No later than ten days after the cancellation or non-renewal of any workers' compensation insurance policy, contract of insurance, or renewal for which an insured has requested cancellation or non-renewal, the insurer shall send the electronic cancellation or non-renewal to the Division. The electronic cancellation or non-renewal shall be represented by Triplicate Codes containing Transaction Set Type Codes "42" & "60", with the exception of Triplicate Code "00-60-64", pursuant to the "Transaction Overview" document, located in Section 4 of the IAIABC EDI Implementation Guide for Proof of Coverage: Insured, Employer, Header, Trailer & Acknowledgement Records, Release 2.1, 6/01/07 Edition and Supplement.

(8) An insurer shall not cancel or non-renew a workers' compensation insurance policy, contract of insurance, or renewal for underwriting reasons represented by Triplicate Code "00-60-64" until and unless 30 days have elapsed after the insurer has electronically sent a cancellation or non-renewal to the Division directly or through a third party vendor.

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Rulemaking Authority 440.185(7), 440.42(3), 440.591, 440.593(5), 627.4133(4) FS. Law Implemented 440.185(7), (9), 440.42(3), 440.593, 627.4133(4) FS. History–New 5-29-05, Amended 1-7-07, 5-17-09.

69L-56.300 Claims EDI Reporting Requirements and Implementation Schedules.

(1)(a) On or before the implementation schedules set out in paragraphs (3)(a) and (b) of this section, every insurer shall file claims information for all "Lost Time/Indemnity," "Medical Only to Lost Time," and "Denied" cases via electronic data interchange (EDI) pursuant to paragraph (d) of this section, rather than by submitting paper forms otherwise required in Rules 69L-3.0045, 69L-3.0091, 69L-3.012, 69L-3.016, 69L-3.0213 and 69L-3.025, F.A.C. The insurer shall file the electronic form equivalent of the First Report of Injury or Illness, Notice of Denial, Claim Cost Report, Notice of Action/Change, and Aggregate Claims Administration Change Report adopted in Rule 69L-3.025, F.A.C., pursuant to the requirements and timeframes set out in Rules 69L-56.301, 69L-56.3012, 69L-56.3013, 69L-56.304 and 69L-56.3045, F.A.C., and in accordance with the "FL Claims EDI R3 Trading Partner Filing Specifications" contained in Section 1 of the "Florida Division of Workers' Compensation Claims Electronic Data Interchange (EDI) R3 Implementation Manual, September 2006" and "Supplement," incorporated herein by reference, and hereafter referred to as the "FL Claims EDI Implementation Manual." A copy of the FL Claims EDI Implementation Manual may be obtained from the Division of Workers' Compensation at its website, http://www.myfloridacfo.com/WC/edi_clms.html.

(b) The insurer or its claim administrator shall electronically report all First Reports of Injury or Illness for which the claim administrator's knowledge of the injury is on or after the date the claim administrator is authorized by the Division to send Electronic First Reports of Injury or Illness in production status (i.e., actual production implementation date). All other electronic form equivalents for denials, periodic claim cost information, changes, suspensions, reinstatements, and cancellations required by this rule shall be electronically reported to the Division, regardless of date of injury, once the claim administrator is approved by the Division to send these electronic filings in production status (i.e., actual production implementation date).

(c) Electronic form equivalents, hereafter also referred to as "Claims EDI Filings" required under this rule do not correspond exactly to, and may require additional information not currently contained on claims forms promulgated under Rules 69L-3.0045, 69L-3.0091, 69L-3.012, 69L-3.016, 69L-3.0213 and 69L-3.025, F.A.C. The term, "insurer," as defined in this rule chapter, refers to the entity responsible for filing electronic form equivalents on or before the compliance dates established in the insurer's Primary and Secondary Implementation Schedules set out in paragraphs 69L-56.300(3)(a) and (b), F.A.C. The term, "claim administrator," as defined in this rule chapter, refers to the trading partner that is sending electronic transactions to the Division, which can be either an insurer filing directly with the Division on its own behalf, or a servicing company/third party administrator filing on the behalf of the insurer. For purposes of this rule, the terms "Claim Administrator" and "Trading Partner" do not mean a third party vendor.

(d) The claim administrator shall report the Claims EDI filings required in Rules 69L-56.301, 69L-56.3012, 69L-56.3013, 69L-56.304, 69L-56.3045 and 69L-56.307, F.A.C., using the First Report of Injury (FROI) and Subsequent Report of Injury (SROI) electronic record layouts adopted by the International Association of Industrial Accident Boards and Commissions (IAIABC). A sample of the FROI, which consists of the 148 and companion R21 records, and a sample of the SROI, which consists of the A49 and companion R22 records, are located in Section 2, "Technical Documentation" of the "IAIABC EDI Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition" and "Supplement," incorporated herein by reference, and hereafter referred to as the IAIABC Claims EDI Release 3 Implementation Guide. A copy of this guide may be obtained from the IAIABC at its website, http://www.iaiabc.org, under "EDI" link, then "Implementation Guides" link.

The claim administrator shall send the FROI (148/R21), SROI (A49/R22), and combination FROI and SROI records with the Maintenance Type Code (MTC) or MTC combinations specified in Rules 69L-56.301, 69L-56.3012, 69L-56.3013, 69L-56.304, 69L-56.3045 and 69L-56.307, F.A.C., to represent the Claims EDI Filing being sent to the

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Division (Example: FROI MTC 04 = Total Denial of an Electronic First Report of Injury or Illness; SROI MTC FN = Electronic Final Claim Cost Report; FROI MTC 00 with SROI MTC IP = Electronic First Report of Injury or Illness where the Initial Payment is made by claim administrator.)

(e) In addition to the Technical Documentation and Business/Technical Process Rules located in Sections 2 and 4, respectively, of the IAIABC Claims EDI Release 3 Implementation Guide, the claim administrator shall comply with information contained in the below documents located in the Claims EDI Trading Partner Filing Specifications of the FL Claims EDI Implementation Manual:

1. "FL Claims EDI R3 Event Table" – Identifies the FROI MTC or SROI MTC, and FROI/SROI MTC combinations required to be sent for an electronic form equivalent required by this rule, and the associated filing time periods by which the FROI and SROI MTC's shall be received by the Division in order to be considered timely filed;

2. "FL Claims EDI R3 Element Requirement Table" – Specifies the data elements required to be sent for each FROI and SROI MTC; and

3. "FL Claims EDI R3 Edit Matrix" – Identifies Division editing that will be applied to data elements and transactions, including transaction sequencing and duplicate processing rules.

(f) The claim administrator shall collect and report all data elements designated with the following codes on the FL Claims EDI R3 Element Requirement Table: "F" (Fatal Technical) – Required to be reported; "M" (Mandatory) – Required to be reported; "MC" (Mandatory/Conditional) – Required to be reported if the condition(s) set out in the table's FROI or SROI Conditional Requirements or Event Benefits Conditions worksheets are met; "IA" (If Applicable/Available) – Required to be reported if the data element is applicable to the claim (e.g., If the claim administrator has knowledge that the employee's Last Name Suffix is "Jr", the claim administrator shall report the Last Name Suffix of "Jr").

(g) Claims EDI filings that comply with data element reporting requirements and pass edits specified in the "FL Claims EDI R3 Element Requirement Table" and the "FL Claims EDI R3 Edit Matrix" shall be accepted and acknowledged by the Division with Application Acknowledgement Code "TA" (Transaction Accepted). Claims EDI filings that receive an Application Acknowledgement Code of "TA" shall be assigned a "Received by Division Date" for purposes of determining whether an EDI filing was timely filed with the Division in accordance with the timeframes identified in the "FL Claims EDI R3 Event Table" and as required in Rules 69L-56.301, 69L-56.3012, 69L-56.3013, 69L-56.304, 69L-56.3045 and 69L-56.307, F.A.C. The date assigned as the "Received by Division Date" is the date the transmission containing the accepted Claims EDI filing was sent to and received by the Division based on the technical transmission requirements set out in subsection 69L-56.310(4), F.A.C. An electronic First Report of Injury or Illness that receives an Application Acknowledgement Code of "TA" shall also be assigned a "Jurisdiction Claim Number" by the Division which the claim administrator shall report on every subsequent Claims EDI filing for that claim. Electronic transactions that do not satisfy data element requirements and edits specified in the "FL Claims EDI R3 Element Requirement Table" and the "FL Claims EDI R3 Edit Matrix" shall be rejected and acknowledged by the Division with Application Acknowledgement Code "TR" (Transaction Rejected). The claim administrator shall correct the error(s) identified in the acknowledgement returned by the Division and re-send the Claims EDI filing to the Division as appropriate (e.g., a transaction receiving fatal error # 0002-057 because it was an extra MTC in the transmission or already on file with the Division is not expected to be re-filed with the Division.)

(h) The claim administrator shall receive and process each acknowledgement transaction (AKC) returned by the Division. The Division will also send, when applicable, a re-acknowledgment transaction (ACR) to identify a Claims EDI filing that was previously acknowledged with Application Acknowledgement code "TR" due to improper processing by the Division, and which was subsequently re-processed and re-assigned an Application Acknowledgement Code of "TA." The claim administrator has the option to either process or not process re-acknowledgement transactions sent by the Division.

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(i) Claims EDI filings acknowledged with Application Acknowledgement Code "TA" (Transaction Accepted) that invoke one or more non-rejectable (non-fatal) edits depicted as "FL" in the "DN-Error Message Table" of the FL Claims EDI R3 Edits Matrix, shall result in an error message that will be communicated by the Division to the claim administrator in a proprietary report, separate from the acknowledgement transaction (AKC). Non-fatal error reports will be posted to the Division's website in a password-protected file, which the claim administrator shall retrieve via the "Claims EDI" link on the Division's web site. The Division will send an email notification to the claim administrator regarding the posting of all non-fatal error reports that require a response from the claim administrator. The claim administrator shall respond to the Division on or before 21 days after the date the report was posted to the Division's web site. The email notification will be sent to the "EDI Business Contact(s)" identified in the claim administrator's "EDI Trading Partner Profile," Form DFS-F5-DWC-EDI-1. The claim administrator shall notify the Division regarding any additions or deletions of "EDI Business Contacts" for this purpose. The claim administrator shall respond to all other inquiries from the Division, including by telephone, concerning written or electronic requests for information, on or before 21 days after the claim administrator's receipt of the request from the Division.

(j) Unless an explanatory letter is alternatively permitted by this rule chapter, paper copies of Forms DFS-F2-DWC-1, DFS-F2-DWC-4 and DFS-F2-DWC-12 shall continue to be provided by the claim administrator to the employee and employer as required by Rules 69L-3.0045, 69L-3.0091, 69L-3.012, 69L-3.025, F.A.C., and as specified in Rules 69L-56.301, 69L-56.3012, 69L-56.304 and 69L-56.3045, F.A.C., and the FL Claims EDI R3 Event Table ("Paper Form" and "Receiver" columns).

(k) The claim administrator shall produce and mail to the employee and employer the informational brochures required in Rules 69L-3.0035 and 69L-3.0036, F.A.C.

(l) Claim administrators who, directly or through its third party vendor, experience a catastrophic event resulting in the insurer's failure to meet the filing requirements of this rule, shall submit a written or electronic request to the Division for approval to submit required electronic form equivalents in an alternative filing timeline. The request shall be sent to the Division within 15 business days after the catastrophic event. The request shall contain a detailed explanation of the nature of the event, date of occurrence, and measures being taken to resume electronic submission. The claim administrator shall also provide an estimated date by which electronic submission of affected EDI filings will be resumed. Approval to submit in an alternative filing timeline shall be granted by the Division if a catastrophic event prevents electronic submission. The approval must be obtained from the Division's Bureau of Data Quality and Collection, 200 E. Gaines Street, Tallahassee, Florida 32399-4226, or via email at claims.edi@myfloridacfo.com. If approved, the electronic form equivalents that were due to be filed during the time the claim administrator was unable to file due to a catastrophic event, shall be sent with Late Reason Code "LB" (Late notification/payment due to a Natural Disaster) or "LC" (Late notification/payment due to an act of Terrorism).

(m) Non-compliance by the claim administrator with the electronic reporting requirements in this Rule shall result in referral to the Division's Bureau of Monitoring and Audit, and may constitute a violation of Section 440.525, F.S.

(2) Trading Partner Profile Documents:

(a) At least two (2) business days prior to sending its first test transmission to the Division, the claim administrator shall send to the Division in an email addressed to claims.edi@myfloridacfo.com, the claim administrator's current profile information using the following forms adopted in Rule 69L-56.001, F.A.C.:

1. "EDI Trading Partner Profile," DFS-F5-DWC-EDI-1 (1/01/2008), and
2. "EDI Trading Partner Insurer/Claim Administrator ID List," DFS-F5-DWC-EDI-2 (10/01/2006), and
3. "EDI Trading Partner Claim Administrator Address List," DFS-F5-DWC-EDI-2A (10/01/2006), and
4. "EDI Transmission Profile – Sender's Specifications, DFS-F5-DWC-EDI-3 (10/01/2006).

Claim administrators filing Electronic First Reports of Injury or Illness or Electronic Claim Cost Reports on a voluntary basis using the IAIABC Release 1 standard formats shall re-file their profile information with the Division

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using the forms in subparagraphs (2)(a)1.-4. above, even if the claim administrator's profile information has not changed since previously reported to the Division.

(b) The claim administrator shall report changes to its profile information required on the forms listed in subparagraphs (2)(a)1.-4. above, at least two (2) business days prior to sending transactions containing revised profile-related information to the Division. The insurer or its claim administrator shall report revisions to its profile information by emailing to the Division at claims.edi@myfloridacfo.com, a revised "EDI Trading Partner Profile," DFS-F5-DWC-EDI-1 (1/01/2008), and if applicable, a revised "EDI Trading Partner Insurer/Claim Administrator ID List", DFS-F5-DWC-EDI-2 (10/01/2006), and if applicable, a revised "EDI Trading Partner Claim Administrator Address List", DFS-F5-DWC-EDI-2A (10/01/2006), and if applicable, a revised "EDI Transmission Profile – Sender's Specifications", DFS-F5-DWC-EDI-3 (10/01/2006). Failure by the claim administrator to report changes to its trading partner profile information using the forms adopted in this rule, including changes to the Submitter ID (i.e., Trading Partner FEIN/Postal Code on the Header Record), shall result in the rejection of an entire transmission or individual transaction(s) containing profile information that is different from that reported on profile documents previously filed with the Division by the claim administrator.

(c) If the insurer or its claim administrator contracts with a new third party vendor, the insurer or its claim administrator shall, at least two (2) business days prior to the effective date of the change in vendors, send an email to the Division at claims.edi@myfloridacfo.com to report the name of the new vendor and effective date on which Claims EDI transactions will be sent via the new vendor.

(3) Claims EDI Implementation Schedules:

(a) Primary Implementation Schedule: The insurer shall comply with the following implementation schedule for reporting Electronic First Reports of Injury or Illness specified in Rule 69L-56.301, F.A.C., Electronic Notices of Denial and Rescinded Denial specified in Rule 69L-56.3012, F.A.C., Electronic Periodic Claim Cost Reports specified in Rule 69L-56.3013, F.A.C., Electronic Notices of Actions or Changes, including Changes in Claims Administration specified in Rule 69L-56.304, F.A.C., and Electronic Cancellations Specified in Rule 69L-56.307, F.A.C. The insurer's Primary Implementation Schedule shall consist of three "test to production" periods as described in subparagraphs (3)(a)1.-3., of this subsection. Each insurer shall be assigned to either the first, second, or third "test to production" period based on the insurer's Division-assigned Insurer Code #. If there are multiple or subsidiary insurer entities within an insurer's corporate structure or organization, the insurer's "test to production" period in the Primary Implementation Schedule will be based on the lowest numeric value assigned to any of the insurer's subsidiary companies. Insurers that write large deductible policies for insureds adjusting their own claims are responsible for ensuring those insureds meet the insurer's required "test to production" timelines and implementation schedules, even if the insured is not using the insurer's computer system to file its Claims EDI Filings with the Division. Claim administrators voluntarily submitting Claims EDI Filings in production status using the IAIABC Release 1 national standard shall convert to Release 3 and be in production status by the same date as that required for the first group of insurers specified in subparagraph (3)(a)1. below, regardless of Insurer Code #. Each "test to production period" shall consist of three calendar months. The insurer's compliance date for the Primary Implementation Schedule shall be the last day of the third month of the insurer's assigned "test to production" period.

1. The first "test to production" period shall commence November 1, 2007, and shall include insurers with Division-assigned Insurer Code #'s 102 through # 199. The compliance date for the Insurer's Primary Implementation Schedule shall be January 31, 2008.

2. The second "test to production" period shall commence February 1, 2008, and shall include insurers with Division-assigned Insurer Code #'s 200 through 599. The compliance date for the insurer's Primary Implementation Schedule shall be April 30, 2008.

3. The third "test to production" period shall commence May 1, 2008 and shall include insurers with Division-assigned Insurer Code #'s 600 through 1122, future Insurer Code #'s 1123 through 4999 and 8000 through #9999. The compliance date for the insurer's Primary Implementation Schedule shall be July 31, 2008.

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(b) Secondary Implementation Schedule: The insurer shall comply with the Secondary Implementation Schedule for reporting the additional Electronic Notices of Action or Change, Suspensions, and Reinstatement of indemnity benefits specified in Rule 69L-56.3045, F.A.C., as follows:

No later than 9 months after the compliance date established in the insurer's Primary Implementation Schedule, the insurer shall commence testing its Electronic Notice of Action or Change, Suspension, and Reinstatement of Indemnity benefits required in Rule 69L-56.3045, F.A.C. The insurer shall be in production status within three months after the commencement of testing, i.e., within one year after the compliance date established in the insurer's Primary Implementation Schedule.

(c) Beginning August 1, 2007, a claim administrator may voluntarily commence testing any electronic form equivalent/MTC with the Division using the IAIABC EDI Release 3 standard for Claims, contingent upon the availability of Division resources.

(d) After a claim administrator has been approved for production status for filing electronic form equivalents required in the Primary Implementation Schedule or Secondary Implementation Schedule, if the claim administrator is unable to receive an Application Acknowledgement Code of "TA" from the Division for an electronic form equivalent required by this rule chapter, the claim administrator may alternatively file the formerly required DWC form adopted in Rule 69L-3.025, F.A.C., for a period not to exceed three months after each of the claim administrator's production implementation dates for the Primary and Secondary Implementation Schedules.

(e) After the conclusion of the three month time period specified in paragraph 69L-56.300(3)(d), F.A.C., above, if the claim administrator is unable to receive an Application Acknowledgement Code of "TA" from the Division for an electronic form equivalent required by this rule chapter, and the claim administrator needs to meet the reporting requirements of this rule, the claim administrator shall submit an e-mail to the Division at claims.edi@myfloridacfo.com to request approval to alternatively file a DWC form pursuant to Rules 69L-3.0045, 69L-3.0091, 69L-3.012, 69L-3.016, 69L-3.0213 and 69L-3.025, F.A.C., in lieu of the electronic form equivalent. The request shall include the following information: Claim Administrator Name and FEIN, Employee Name, Employee ID Number (Social Security Number or Division Assigned Number), Date of Injury, Claim Administrator File Number, Maintenance Type Code (MTC), Date Transmission Sent for the MTC(s) attempted unsuccessfully, the DWC form requesting to be filed (i.e., DWC-13), and an explanation of the reasons electronic submission failed. If the Division approves the claim administrator's request to send a DWC form in lieu of the electronic form equivalent, all subsequent filings due for the claim shall be sent via EDI; the claim administrator shall not file additional DWC forms for the claim unless the claim administrator has received advance approval from the Division.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07, Amended 5-17-09.

69L-56.301 Electronic First Report of Injury or Illness.

On or before the compliance date established in the insurer's Primary Implementation Schedule set forth in paragraph 69L-56.300(3)(a), F.A.C., the insurer shall file the electronic form equivalent for claims information otherwise reported on Form DFS-F2-DWC-1 adopted in Rules 69L-3.0045 and 69L-3.025, F.A.C. Pursuant to Section 440.593(1) F.S., the Division may establish different deadlines for filing required reports electronically than are otherwise required when reporting information by other means. Accordingly, notwithstanding the deadlines for filing the injury report by other means as set forth in Section 440.185(2), FS., the insurer or its claim administrator shall send to the Division the electronic form equivalent of the First Report of Injury or Illness for the following cases, and by the following filing time periods:

(1) Initial Payment for "Lost Time Case" or "Medical Only to Lost Time Case"
(FROI MTC 00 with SROI MTC IP, EP, CD, VE, or PY as found in the IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition):

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(a) Where the initial payment of indemnity benefits, excluding Temporary Partial benefits, Impairment Income benefits, and Lump Sum Payment/Settlement, is made by the claim administrator, or where the employer is paying salary in lieu of compensation, or for a compensable death with no known dependents, or a compensable volunteer:

1. If disability is immediate and continuous for 8 or more calendar days after the workers' compensation injury, an Electronic First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before 21 days after the claim administrator's knowledge of the injury. The claim administrator shall report Claim Type "I" (Lost Time/Indemnity).

2. If the first 7 days of disability are nonconsecutive or delayed, an Electronic First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before 13 days after the claim administrator's knowledge of the employee's 8th day of disability. The claim administrator shall report the "Initial Date of Lost Time" (i.e., the employee's 8th day of disability) and the "Date Claim Administrator Had Knowledge of Lost Time". The claim administrator shall also report Claim Type "L" (Became Lost Time/Indemnity).

3. The Electronic First Report of Injury or Illness shall be represented by sending the FROI and SROI records as follows:

a. Initial Payment by Claim Administrator: FROI MTC 00 (Original) with SROI MTC IP (Initial Payment);

b. Employer Paid Salary in Lieu of Compensation: FROI MTC 00 (Original) with SROI MTC EP (Employer Paid);

c. Compensable Death, No Dependents/Payees: FROI MTC 00 (Original) with SROI MTC CD (Compensable Death);

d. Compensable Volunteer: FROI with MTC 00 (Original) with SROI MTC VE (Volunteer);

(b) Where the initial payment of indemnity benefits is for Temporary Partial benefits, Impairment Income benefits, or results from a Lump Sum Payment/Settlement, an Electronic First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before 14 days after the date the initial payment of benefits was mailed to the employee or to the employee's legal representative.

1. The Electronic First Report of Injury or Illness shall be represented by sending the FROI and SROI records as follows:

a. Initial Payment of Temporary Partial Benefits (TP): FROI MTC 00 (Original) with SROI MTC IP (Initial Payment) and Benefit Type Code "070" (Temporary Partial);

b. Initial Payment of Impairment Income Benefits (IB): FROI MTC 00 (Original) with SROI MTC IP (Initial Payment) and Benefit Type Code "030" (Permanent Partial Scheduled);

c. Initial Payment of Lump Sum Payment/Settlement: FROI MTC 00 (Original) with SROI MTC PY (Payment Report) and Benefit Type Code that applies to the specific benefit(s) covered by the lump sum payment/settlement.

(2) "Denied Case":

(FROI MTC 04, or SROI MTC PD with applicable FROI MTC as found in the IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition).

(a) Full/Total Denial – If, by the 14th day after the claim administrator's knowledge of the injury, the employee sustains disability as defined in Section 440.02, F.S., and the claim administrator's initial disposition is to deny the case in its entirety (i.e., both medical and indemnity benefits are denied), an Electronic First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before 21 days after the claim administrator's knowledge of the injury. The claim administrator shall report Claim Type Code "L" (to represent the full denial of a "Medical Only to Lost Time Case") or Claim Type Code "I" (to represent the full denial of a "Lost Time/Indemnity Case").

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1. The Electronic First Report of Injury or Illness reporting a “Full/Total Denial” shall be represented by sending FROI MTC 04 (Denial).

2. The electronic form equivalent of Form DFS-F2-DWC-12 adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., required in Rule 69L-56.3012, F.A.C., to be filed with the Division to explain the reason(s) for the denial, shall be accomplished by reporting the applicable Full Denial Reason Code(s), Full Denial Effective Date, and Denial Reason Narrative on the same FROI MTC 04 (Denial).

(b) Medical Only Case that becomes a Total Denial – If the claim administrator is making the decision to deny the case in its entirety (i.e., both medical and indemnity benefits are denied) after the claim administrator’s initial disposition to accept compensability of a “Medical Only Case,” an Electronic First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division and is assigned an Application Acknowledgement Code of “TA” (Transaction Accepted) on or before 14 days after the claim administrator’s decision to deny the entire claim. The claim administrator shall report Claim Type Code “M” (to represent a “Medical Only Case” that is being totally denied).

1. The Electronic First Report of Injury or Illness to report the denial of both indemnity and medical benefits on a case initially determined to be a Medical Only case, shall be represented by sending a FROI MTC 04 (Total Denial).

2. The electronic form equivalent of Form DFS-F2-DWC-12 adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., required in Rule 69L-56.3012, F.A.C., to be filed with the Division to explain the reason(s) for the denial, shall be accomplished by reporting the applicable Full Denial Reason Code(s), Full Denial Reason Effective Date, and Denial Reason Narrative on the same FROI MTC 04 (Denial).

(c) Partial (Indemnity Only) Denial or Medical Only Case that becomes a Partial Denial – If the claim administrator’s initial disposition of a claim is the acceptance of compensability but denial of indemnity benefits only, an Electronic First Report of Injury or Illness will be considered timely filed with the Division when it is received by the Division and is assigned an Application Acknowledgement Code of “TA” (Transaction Accepted) on or before 14 days after the claim administrator’s decision to deny indemnity benefits.

1. The Electronic First Report of Injury or Illness reporting a Partial (Indemnity Only) Denial shall be represented by sending FROI MTC 00 (Original) with SROI MTC PD (Partial Denial).

2. The electronic form equivalent of the DFS-F2-DWC-12 adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., required in Rule 69L-56.3012, F.A.C., to be filed with the Division to explain the reason(s) for the denial, shall be accomplished by reporting the applicable Partial Denial Code (“A” or “E”) and Denial Reason Narrative on the same SROI MTC PD (Partial Denial).

(3) If the claim administrator receives notification of an injury from the employer via telephone or electronic data interchange where no Form DFS-F2-DWC-1, First Report of Injury or Illness adopted in Rules 69L-3.0045 and 69L-3.025, F.A.C., has been completed and provided to the employee and employer, the claims administrator shall produce and send to the employee and employer within three (3) business days of the claims administrator’s knowledge of the injury, either Form DFS-F2-DWC-1 or Form IA-1 adopted in Rules 69L-3.0045 and 69L-3.025, F.A.C. The claim administrator shall not send Form IA-1 to the Division to report the First Report of Injury or Illness.

(4) Any insurer failing to timely file the Electronic First Report of Injury or Illness required under this section is subject to administrative penalties assessable by the Division according to the provisions of Rule 69L-24.0231, F.A.C., and as allowed for in Section 440.185(9), F.S. If the initial payment is not timely issued in accordance with the time period prescribed in Section 440.20, F.S., or the Electronic First Report of Injury or Illness is not timely filed with the Division in accordance with this section, the claim administrator shall report the appropriate Late Reason Code(s) when sending the Electronic First Report of Injury or Illness. If the initial payment and Electronic First Report of Injury or Illness were originally reported to another jurisdiction and the claim was subsequently transferred to Florida, the claim administrator shall include Late Reason Code “L4” (late notification, jurisdiction transfer) on the Electronic First Report of Injury or Illness that is being re-filed in Florida.

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(5) An Electronic First Report of Injury or Illness for a "Medical Only Case" shall not be sent to the Division unless the claim administrator has received a written or electronic request from the Division, or if the claim began as a Medical Only Case and is being reported to the Division as a Full or Partial Denial of indemnity benefits.

(6) When both FROI and SROI transactions are sent to report the Electronic First Report of Injury or Illness, the claim administrator shall ensure the values sent on the FROI and SROI records for data elements identified in the "FROI to SROI" column of the Match Data Table contained in the FL Claims EDI R3 Edit Matrix are the same value.

(7) An Electronic First Report of Injury or Illness filed in accordance with Rule 69L-56.301, F.A.C., or a paper First Report of Injury or Illness must have been received and accepted by the Division before any subsequent electronic filings will be accepted.

(8) Only 2002 NAICS Codes shall be reported for the Industry Code and must be sent as a minimum of 5 digits. If the insured is a Professional Employment Organization (PEO), the Industry/NAICS Code should represent the nature of the client's/employer's business.

(9) If the employee does not have or wish to provide a Social Security Number, the claim administrator shall contact the Division by following the instructions provided on the Division's website: http://www.myfloridacfo.com/WC/organization/odqc.html (under Records Management – Division-Assigned Numbers) and obtain a Division-assigned number. Upon receipt of the employee's Social Security Number, the claim administrator shall file MTC 02 (Change) and provide the employee and employer with Form DFS-F2-DWC-4, pursuant to Rule 69L-3.025, F.A.C.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07, Amended 5-17-09.

69L-56.3012 Electronic Notice of Denial and Rescinded Denial.

(FROI/SROI MTC 04, SROI MTC PD as found in the IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition)

On or before the compliance date established in the insurer's Primary Implementation Schedule set forth in paragraph 69L-56.301(3)(a), F.A.C., the insurer shall file the electronic form equivalent for the denial information otherwise reported on Form DFS-F2-DWC-12, adopted in Rules 69L-3.012 and 69L-3.025, F.A.C. The claim administrator shall send to the Division an Electronic Notice of Denial to report the reason for the denial of indemnity benefits for the following types of denial notices, and by the following time periods:

(1) Electronic Notice of Denial – Full (Both Indemnity and Medical Benefits Denied):

(a) If the entire compensability of the claim is initially denied and both indemnity and medical benefits will not be paid by the claim administrator, the claim administrator shall file the Electronic Notice of Denial by reporting the applicable Full Denial Reason Code(s) and Full Denial Effective Date on the same FROI MTC 04 (Denial) the claim administrator sends to the Division to report the Electronic First Report of Injury or Illness, in accordance with filing time periods in subsection 69L-56.301(2), F.A.C. The Denial Reason Narrative shall also be sent on the FROI MTC 04 (Denial) to supplement the Full Denial Reason Code(s).

(b) If the claim administrator initially accepts compensability but subsequently denies liability for the entire claim after having previously paid indemnity benefits and the Electronic First Report of Injury or Illness has already been filed with the Division, the claim administrator shall file the Electronic Notice of Denial by sending a SROI MTC 04 (Denial). The Electronic Notice of Denial will be considered timely filed with the Division if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before 14 days after the date the claim administrator decided to deny benefits. The claim administrator shall report the applicable Full Denial Reason Code(s) and Full Denial Effective Date on the SROI MTC 04 (Denial). The Denial Reason Narrative shall also be sent on the SROI MTC 04 (Denial) to supplement the Denial Reason Code(s).

(c) In addition to filing the Electronic Notice of Denial with the Division, the claim administrator shall produce and mail a paper copy of Form DFS-F2-DWC-12, Notice of Denial, adopted in Rules 69L-3.012 and 69L-3.025,

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F.A.C., to the employer and employee, in accordance with the filing time period set out for Form DFS-F2-DWC-12 in Rule 69L-3.012, F.A.C.

(2) Electronic Notice of Denial – Partial (Indemnity Only Benefits Denied):

(a) If all indemnity benefits are initially denied but some or all medical benefits will be provided, the claim administrator shall file the Electronic Notice of Denial by reporting Partial Denial Code "A" (Denying Indemnity in whole, but not Medical) or partial Denial Code "E" (Denying Indemnity in whole and Medical in part) on the same SROI MTC PD (Partial Denial) the claim administrator sends with FROI MTC 00 (Original) to report the Electronic First Report of Injury or Illness in accordance with the filing time periods in subsection 69L-56.301(2), F.A.C. The claim administrator shall also report the "Denial Reason Narrative" on the SROI MTC PD to explain the reason for the denial of indemnity benefits.

(b) If payment of a specific indemnity benefit(s) is denied in whole or part subsequent to the claim administrator's initial disposition of the claim and the Electronic First Report of Injury or Illness has already been filed with the Division, the claim administrator shall file the Electronic Notice of Denial by sending a SROI MTC PD (Partial Denial). The Electronic Notice of Denial will be considered timely filed with the Division if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before 14 days after the date the claim administrator decided to deny benefits. The claim administrator shall report the applicable Partial Denial Code as follows: "A" (Denying Indemnity in Whole, but not Medical); "B" (Denying Indemnity in part, but not Medical); "E" (Denying Indemnity in whole and Medical in part); or "G" (Denying both Indemnity and Medical in part). The claim administrator shall also report the "Denial Reason Narrative" on the SROI MTC PD to explain the reason for the denial of indemnity benefits.

(c) In addition to filing the Electronic Notice of Denial with the Division, the claim administrator shall produce and mail a paper copy of Form DFS-F2-DWC-12, Notice of Denial, adopted in Rules 69L-3.012 and 69L-3.025,F.A.C., to the employer and employee, in accordance with the filing time period set out for Form DFS-F2-DWC-12 in Rule 69L-3.012, F.A.C.

(3) Electronic Notice of Denial - Medical Only Case that becomes a Total or Partial (Indemnity Only) Denial:

(a) If a case is initially determined to be a compensable Medical Only Case and the claim administrator subsequent to its initial disposition denies both medical and indemnity benefits, i.e., Full/Total Denial, the claim administrator shall file an Electronic Notice of Denial with the Division by reporting the applicable Full Denial Reason Code(s), Full Denial Effective Date, and Denial Reason Narrative on the same FROI MTC 04 (Total Denial) the claim administrator sends to report the Electronic First Report of Injury or Illness, in accordance with the filing time period in subsection 69L-56.301(2), F.A.C.

(b) If a case is initially determined to be a compensable Medical Only Case and the claim administrator subsequent to its initial disposition denies indemnity benefits in whole but some or all medical benefits will be provided, i.e., Partial (Indemnity Only) Denial, the claim administrator shall file an Electronic Notice of Denial with the Division by reporting the applicable Partial Denial Reason Code(s) and Denial Reason Narrative on the same SROI MTC PD (Partial Denial) the claim administrator sends with the FROI MTC 00 (Original) to report the Electronic First Report of Injury or Illness, in accordance with the filing time periods in subsection 69L-56.301(2), F.A.C.

(c) In addition to filing the Electronic Notice of Denial with the Division, the claim administrator shall produce and mail a paper copy of Form DFS-F2-DWC-12, Notice of Denial, adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., to the employer and employee, in accordance with the filing time period set out for Form DFS-F2-DWC-12 in Rule 69L-3.012, F.A.C.

(4) If the claim administrator is invoking the "120 day rule" allowed in Section 440.192(8), F.S., when initiating payment without prejudice to its right to subsequently deny benefits, it may send the Agreement to Compensate Code "W" (Without Liability) on the same SROI MTC IP (Initial Payment) being sent to report the Electronic First Report of Injury or Illness.

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(5) The claim administrator shall not file an Electronic Notice of Denial with the Division if it is denying payment of a medical benefit only. However, the claim administrator shall provide Form DFS-F2-DWC-12, Notice of Denial, adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., to the employee, employer, and the party(s) requesting payment or authorization of a medical benefit.

(6) Electronic Notice of Rescinded Denial-

(a) Rescission of a Full Denial. If the claim administrator denied the claim in its entirety, either initially by sending an Electronic First Report of Injury or Illness FROI MTC 04 (Denial) or subsequent to its initial disposition by sending an Electronic Notice of Denial SROI MTC 04 (Denial), or if the claim administrator acquired a denied claim for which a First Report of Injury or Illness is already on file with the Division but subsequently accepts compensability of the claim, the claim administrator shall file an Electronic Notice of Rescinded Denial with the Division to report the change in disposition of the claim. The Electronic Notice of Rescinded Denial will be considered timely filed if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before the 14 days after the date the denial was rescinded. The claim administrator shall also notify the employee and employer about the decision to rescind the full denial by sending to the employee and employer, Form DFS-F2-DWC-12, Notice of Denial, pursuant to Rules 69L-3.012 and 69L-3.025, F.A.C., or an explanatory letter. The Electronic Notice of Rescinded Denial shall be represented by sending a SROI MTC as follows:

1. The Electronic Notice of Rescinded Denial reporting payment of indemnity benefits shall be represented by sending SROI MTC IP (Initial Payment); SROI MTC AP (Acquired/Payment) for an acquired claim; SROI MTC PY (Payment Report) reporting a lump sum payment or settlement of indemnity benefits; SROI MTC RB (Reinstatement of Benefits) to report reinstatement of indemnity benefits that were paid by the claim administrator prior to the denial. The claim administrator shall report the "Denial Rescission Date", the date payment of indemnity benefits was mailed, and the type of indemnity benefits paid on the SROI MTC IP, AP, PY, or RB.

2. The Electronic Notice of Rescinded Denial reporting acceptance of a compensable death case where there are no known dependants shall be represented by sending SROI MTC CD (Compensable Death, No Dependents/Payees). The claim administrator shall report the "Denial Rescission Date" on the SROI MTC CD.

3. The Electronic Notice of Rescinded Denial reporting acceptance of a compensable volunteer shall be represented by sending SROI MTC VE (Volunteer). The claim administrator shall report the "Denial Rescission Date" on the SROI MTC VE.

4. The Electronic Notice of Rescinded Denial reporting reinstatement of indemnity benefits by the employer following a denial of indemnity benefits previously paid by the employer shall be represented by sending SROI MTC ER (Employer Reinstatement). The claim administrator shall report the "Denial Rescission Date" on the SROI MTC ER.

5. The Electronic Notice of Rescinded Denial reporting acceptance of compensability where indemnity or medical benefits will be denied in whole or in part, shall be represented by sending SROI MTC PD (Partial (Indemnity Only) Denial). The claim administrator shall report the "Denial Rescission Date" on the SROI MTC PD.

(b) Rescission of a Partial (Indemnity Only) Denial. If the claim administrator initially denied payment of indemnity benefits only and filed an Electronic First Report of Injury or Illness FROI 00 (Original) and SROI MTC PD (Partial Denial) with the Division, or the claim administrator acquired a Partial Denial claim for which a First Report of Injury or Illness is already on file with the Division and the claim administrator subsequently pays indemnity benefits, the claim administrator shall file an Electronic Notice of Rescinded Denial with the Division to report a change in disposition of the claim. The Electronic Notice of Rescinded Denial will be considered timely filed if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before the 14 days after the date the denial was rescinded. The claim administrator shall also notify the employee and employer about the decision to rescind the Partial (Indemnity Only) Denial by sending to the employee and employer, Form DFS-F2-DWC-12, Notice of Denial, pursuant to Rules 69L-3.012 and 69L-3.025,

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F.A.C., or explanatory letter. The Electronic Notice of Rescinded Denial shall be represented by sending a SROI MTC as follows:

1. The Electronic Notice of Rescinded Denial reporting payment of indemnity benefits shall be represented by sending SROI MTC IP (Initial Payment), or SROI MTC AP (Acquired/Payment) for an acquired claim. The Electronic Notice of Rescinded Denial reporting a lump sum payment or settlement of indemnity benefits shall be represented by sending SROI MTC PY (Payment Report). The claim administrator shall include the "Denial Rescission Date," the date the initial payment of indemnity benefits was mailed, and the type of indemnity benefits paid on the SROI MTC IP, AP, or PY.

2. The Electronic Notice of Rescinded Denial reporting acceptance of a compensable death case where there are no known dependants shall be represented by sending SROI MTC CD (Compensable Death, No Dependents/Payees). The claim administrator shall report the "Denial Rescission Date" on the SROI MTC CD

3. The Electronic Notice of Rescinded Denial reporting acceptance of a compensable volunteer shall be represented by sending SROI MTC VE (Volunteer). The claim administrator shall report the "Denial Rescission Date" on the SROI MTC VE.

4. The Electronic Notice of Rescinded Denial reporting reinstatement of indemnity benefits by the employer following a denial of indemnity benefits previously paid by the employer, shall be represented by sending SROI MTC ER (Employer Reinstatement). The claim administrator shall report the "Denial Rescission Date" on the SROI MTC ER.

(c) Rescission of Partial (Indemnity Only) Denial After Payment. If the claim administrator initially paid indemnity benefits and subsequently denied payment of indemnity benefits only and filed an Electronic Notice of Denial SROI MTC PD (Partial Denial) with the Division and elects to pay indemnity benefits again, or if the claim administrator acquired a claim for which indemnity benefits were previously paid and subsequently denied and the acquiring claim administrator subsequently pays indemnity benefits, the claim administrator shall file an Electronic Notice of Rescinded Denial with the Division to report a change in disposition of the claim. The Electronic Notice of Rescinded Denial will be considered timely filed if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before the 14 days after the date the denial was rescinded. The claim administrator shall also notify the employee and employer about the decision to rescind the partial denial by sending to the employee and employer, Form DFS-F2-DWC-12, Notice of Denial, pursuant to Rules 69L-3.012 and 69L-3.025, F.A.C., or explanatory letter. The Electronic Notice of Rescinded Denial reporting reinstatement of indemnity benefits following a denial of indemnity benefits shall be represented by sending SROI MTC RB (Reinstatement of Benefits). The Electronic Notice of Rescinded Denial shall report the "Denial Rescission Date" and the type of indemnity benefits paid, on the SROI MTC RB.

(7) Any insurer failing to timely send the Electronic Notice of Denial in accordance with the filing time periods prescribed in this subsection shall be subject to administrative penalties assessable by the Division in accordance with the provisions of Rule 69L-24.021, F.A.C., and Section 440.525(4), F.S.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07, Amended 5-17-09.

69L-56.3013 Electronic Periodic Claim Cost Reports.
(SROI MTC SA, FN as found in the IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition).
On or before the compliance date established in the insurer's Primary Implementation Schedule set forth in paragraph 69L-56.300(3)(a), F.A.C., the insurer shall file the electronic form equivalent for claim cost information otherwise reported on Form DFS-F2-DWC-13 adopted in Rules 69L-3.016 and 69L-3.025, F.A.C. If payment has been made for any of the Benefit Type (BT) Codes or Other Benefit Type (OBT) Codes listed in subsections (1) and (2) of this section, the claim administrator shall report on the Electronic Claim Cost Report, the cumulative amount paid (i.e., Benefit Type Amount Paid, Other Benefit Type Amount) in dollars and cents for each applicable BT Code, with the exception of BT Codes reporting employer payment, and OBT Code. The claim administrator shall also

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report the amount of weeks (i.e., Benefit Type Claim Weeks) and/or days (i.e., Benefit Type Claim Days), the effective date of each indemnity benefit (i.e., Benefit Period Start Date), and the date through which indemnity benefits were paid at the time of reporting (i.e., Benefit Period Through Date), unless otherwise indicated below. For purposes of the Electronic Claim Cost Report, the Benefit Period Start Date shall be reported as the earliest date benefits were paid for a Benefit Type Code, regardless of whether multiple disability periods were paid for the Benefit Type Code.

(1) BENEFIT TYPE (BT) CODES:

(a) BT Code 010: Fatal/Death

(b) BT Code 020: Permanent Total (PT)

(c) BT Code 021: Permanent Total Supplemental (PT Supp)

(d) BT Code 030: Permanent Partial Scheduled/Impairment Income Benefits (IB) (Dates of Injury on or after 1/1/94).

The claim administrator shall not report BT Code 030 (IB) or BT Code 530 (Lump Sum Payment/Settlement of IB) if one or more of the following BT Codes have been paid: BT Code 020 (PT), 021 (PT Supp), 520 (Lump Sum Payment/Settlement of PT), or 521 (Lump Sum Payment/Settlement of PT Supp).

(e) BT Code 030: Permanent Partial Scheduled/Wage Loss Benefits (Dates of Injury prior to 1/1/94).

1. Benefit Type Claim Weeks, Benefit Type Claim Days, Benefit Period Start Date and Benefit Period Through Date are not required to be reported.

(f) BT Code 040: Permanent Partial Unscheduled/Supplemental Income Benefits (SB) (Dates of Injury 1/194 through 9/30/2003).

1. BT Code 040 (SB) or 540 (Lump Sum Payment/Settlement of SB) shall not be sent as the earliest/only indemnity benefit paid.

(g) BT Code 050: Temporary Total (TT)

(h) BT Code 051: Temporary Total Catastrophic (TT @ 80%).

(i) BT Code 070: Temporary Partial (TP)

For Dates of Injury prior to 1/1/94, Benefit Type Claim Weeks, Benefit Type Claim Days, Benefit Period Start Date and Benefit Period Through Date are not required to be reported.

(j) BT Code 090: Permanent Partial Disfigurement/Permanent Impairment Benefits (PI) (Dates of Injury 8/1/79 through 12/31/1993).

1. The claim administrator shall not report BT Code 090 (PI) or BT Code 590 (Lump Sum Payment/Settlement of PI) if one or more of the following BT Codes have been paid: BT Code 020 (PT), 021 (PT Supp), 520 (Lump Sum Payment/Settlement of PT), or 521 (Lump Sum Payment/Settlement of PT Supp).

2. Benefit Type Claim Weeks, Benefit Type Claim Days, Benefit Period Start Date and Benefit Period Through Date are not required to be reported.

(k) BT Code 240: Employer Paid Unspecified/Salary in Lieu of Compensation

1. The claim administrator may alternatively report BT Code 242: Employer Paid Vocational Rehab Maintenance/specifically for Salary in Lieu of Comp for TT – Training and Education; BT Code 250: Employer Paid Temporary Total/specifically for Salary in Lieu of Comp for TT; BT Code 251: Employer Paid Temporary Total Catastrophic/specifically for Salary in Lieu of Comp for TT @ 80%; and/or BT Code 270: Employer Paid Temporary Partial/specifically for Salary in lieu of Comp for TP Payable; however, if the claim administrator's knowledge of the injury is on or after its production implementation date for reporting the Electronic Claim Cost Report, BT Codes 242, 250, 251, and 270 shall not be reported with BT Code 240.

2. Benefit Type Amount Paid is not required to be reported for BT Codes 240, 242, 250, 251, and 270.

(l) BT Code 410: Vocational Rehab Maintenance/TT Training and Education.

(m) BT Code 500: Unspecified Lump Sum Payment/Settlement of indemnity benefits

Benefit Type Claim Weeks, Benefit Type Claim Days, Benefit Period Start Date and Benefit Period Through Date are not required to be reported.

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(n) BT Code 501: Medical Lump Sum Payment/Settlement. The claim administrator is not required to report BT Code 501: Medical Lump Sum Payment/Settlement, unless it is accompanied or preceded by BT Code 500 Unspecified Lump Sum Payment/Settlement.

1. If BT Code 501 is the only payment reported, the Electronic Claim Cost Report will be rejected.

2. Benefit Type Claim Weeks, Benefit Type Claim Days, Benefit Period Start Date and Benefit Period Through Date are not required to be reported.

(o) BT Codes 5xx: Lump Sum Payment/Settlement of a specific BT Code in paragraphs (1)(a) through (l) of this subsection.

Benefit Type Claim Weeks, Benefit Type Claim Days, Benefit Period Start Date and Benefit Period Through Date are not required to be reported.

(2) OTHER BENEFIT TYPE (OBT) CODES:

(a) OBT Code 300: Funeral Expenses

(b) OBT Code 310: Total Penalties

The claim administrator shall not report OBT Code 310 for cases where the Date Claim Administrator Had Knowledge of the Injury is prior to the claim administrator's production implementation date for Electronic Claim Cost Reports (MTC's SA and FN).

(c) OBT Code 311 – Total Employee Penalties

The claim administrator shall file OBT Code 311(versus OBT Code 310) for cases where the Date Claim Administrator Had Knowledge of the Injury is on or after the claim administrator's production implementation date for Electronic Claim Cost Reports (MTC's SA and FN).

(d) OBT Code 320 – Total Interest

The claim administrator shall not report OBT Code 310 for cases where the Date Claim Administrator Had Knowledge of the Injury is prior to the claim administrator's production implementation date for Electronic Claim Cost Reports (MTC's SA and FN).

(e) OBT Code 321 – Total Employee Interest

The claim administrator shall file OBT Code 321(versus OBT Code 320) for cases where the Date Claim Administrator Had Knowledge of the Injury is on or after the Claim Administrator's production implementation date for Electronic Claim Cost Reports (MTC's SA and FN).

(f) OBT Code 370: Total Other Medical

OBT Code 370 includes medical expenses (e.g., expenses to build a ramp for a wheelchair-bound employee) not otherwise required to be reported to the Division pursuant to Rule 69L-7.602, F.A.C., (i.e., physician, dental, hospital, pharmacy or durable medical expenses).

(g) OBT Code 380: Total Vocational Rehabilitation Evaluation

(h) OBT Code 390: Total Vocational Rehabilitation Education

(i) OBT Code 400: Total Other Vocational Rehabilitation

(j) OBT Code 430: Total Unallocated Prior Indemnity Benefits

(k) OBT Code 475: Total Medical Travel Expenses

(3) The claim administrator shall send Electronic Periodic Claim Cost Reports to the Division for the following cases and by the filing time periods in subsection (3) of this section:

(a) "Lost Time/Indemnity Case";

(b) "Medical Only to Lost Time Case;

(c) "Denied Case" for which any indemnity benefit was paid prior to or after the denial.

(4)(a) Electronic Sub-Annual Claim Cost Report: The claim administrator shall report the Electronic Sub-Annual Claim Cost Report by sending SROI MTC SA (Sub-Annual) every 6 months after the date of injury until the claim is closed. The first Electronic Sub-Annual Claim Cost Report will be considered timely filed with the Division if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) within 30 days after six (6) months from the date of injury. All subsequent Electronic Sub-Annual Claim

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Cost Reports shall be sent to the Division every six (6) months thereafter. A subsequent Electronic Sub-Annual Claim Cost Report will be considered timely filed with the Division if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) within 30 days of the due date as determined by the following: A subsequent MTC SA due date will be determined by adding six month intervals to the month of injury (e.g. Date of Injury (DOI) = 3/15/06, MTC SA due 9/15/06, next MTC SA due 3/15/07). If the resulting MTC SA due date is not a valid calendar date, the due date for that MTC SA will default to last day of the calculated month (e.g. DOI = 8/30/06, MTC SA due 2/28/07, next MTC SA due 8/30/07).

1. The first Electronic Sub-Annual Claim Cost Report shall not be sent to the Division earlier than six months after the date of injury. However, if the claim administrator closed the case prior to 6 months after the date of injury, the first Electronic Claim Cost Report may be sent prior to six (6) months after the date of injury if it is sent as an Electronic Final Claim Cost Report (MTC FN). If the claim did not become a "Lost Time/Indemnity Case" until more than six (6) months after the date of injury, the first Electronic Sub-Annual Claim Cost Report shall be filed when the next "6 month" SROI MTC SA becomes due (e.g., disability began 9 months after the DOI, 1st MTC SA due 12 months after DOI; disability began 13 months after DOI, 1st MTC SA due 18 months after DOI).

2. Subsequent Electronic Sub-Annual Claim Cost Reports sent more than 7 days prior to the required six (6) month filing interval will be processed as an amendment to the previous Electronic Sub-Annual Claim Cost Report and will not fulfill the filing requirement for the next required Electronic Sub-Annual Claim Cost Report.

(b) Electronic Final Claim Cost Report: The claim administrator shall report the Electronic Final Claim Cost Report by sending SROI MTC FN (Final) for all cases closed since the last required filing of a periodic report. The Electronic Final Claim Cost Report will be considered timely filed with the Division if it is received by the Division and is assigned an Application Acknowledgement Code of "TA" (Transaction Accepted) on or before 30 days after the due date of the sub-annual.

1. The Electronic Final Claim Cost Report may be sent prior to the due date of the sub-annual if the claim administrator closes the case and will not be paying any further medical or indemnity benefits.

2. If the claim administrator issues payment or changes the amount paid for any Benefit Type Code or Other Benefit Code identified in subsections 69L-56.3013(1) and (2), F.A.C., since the filing of the previous Final Claim Cost Report, the claim administrator shall send an Electronic Final Claim Cost Report on or before 30 days after the due date of the sub-annual to summarize benefits paid since the last Final Claim Cost Report filed with the Division.

3. If the claim administrator is re-opening the claim to pay on-going indemnity benefits, the Electronic Periodic Claim Cost Report should be sent as an Electronic Sub-Annual (SA) Claim Cost Report on or before 30 days after the due date of the Sub-Annual.

4. The claim administrator shall file another Electronic Final (FN) Claim Cost Report if it has paid additional amounts for one or more of the following Other Benefit Type Codes: OBT Code 370 (Total Other Medical), OBT Code 380 (Total Vocational Rehabilitation Evaluation), OBT Code 390 (Total Vocational Rehabilitation Education), OBT Code 400 (Total Other Vocational Rehabilitation), or OBT Code 475 (Total Medical Travel Expenses).

(5) Any insurer failing to timely send an Electronic Periodic Claim Cost Report in accordance with the filing time periods prescribed in this subsection shall be subject to administrative penalties assessable by the Division in accordance with the provisions of Rule 69L-24.021, F.A.C. and Section 440.525(4), F.S.

(6) In the event claims are acquired from another claim administrator, the insurer shall ensure that its former claim administrator provides the acquiring claim administrator with the total amounts paid for indemnity benefits paid prior to the acquisition of the claim by the new claim administrator. Notwithstanding the provision of specific claim costs amounts paid by the former claim administrator(s) for each indemnity benefit type, the acquiring claim administrator shall report on the next required Electronic Periodic Claim Cost Report, cumulative totals for all indemnity benefits paid by the former claim administrator(s) on a transferred case as follows: Cumulative totals for indemnity costs paid by the former claim administrator(s) shall be reported under Other Benefit Type Code 430 (Total Unallocated Prior Indemnity Benefits). The acquiring claim administrator shall report any specific costs paid

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by the acquiring claim administrator for each applicable Benefit Type Code (indemnity benefits) and Other Benefit Type Code, in addition to the unallocated indemnity amount paid by the former claim administrator(s).

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07, Amended 5-17-09.

69L-56.304 Electronic Notice of Action or Change, Including Change in Claims Administration, Required by the Insurer's Primary Implementation Schedule.

(FROI/SROI MTC 02, FROI MTC AQ, AU, SROI IP, PY, EP as found in the IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition)

(1) Electronic Notice of Action or Change (MTC 02). On or before the compliance date established in the insurer’s Primary Implementation Schedule set forth in paragraph 69L-56.300(3)(a), F.A.C., the insurer shall file an Electronic Notice of Action or Change for reporting changes to the information specified in paragraphs (1)(a) and (b) of this section. The claim administrator shall file the FROI or SROI MTC 02 (Change) on or before 14 days after the claim administrator has knowledge of the new or changed information. However, MTC 02 shall not be sent if a data element changes as a result of an event that requires the reporting of another MTC in accordance with the definition of Maintenance Type Code (MTC) in the Data Dictionary located in Section 6 of the IAIABC Claims EDI Release 3 Implementation Guide. If there is a change in Insurer FEIN or Claims Administrator FEIN, Claim Administrator Postal Code, and Claim Administrator Claim Number due to the acquisition of a claim, the claim administrator shall file MTC AQ or AU with applicable SROI pursuant to subsection (2) of this section.

(a) The claim administrator shall file a FROI or SROI MTC 02 (Change) as noted below, and provide Form DFS-F2-DWC-4 to the employee and employer pursuant to Rules 69L-3.0091 and 69L-3.025, F.A.C., if any of the following data elements are changed or reported for the first time:

1. Insurer FEIN not due to change in claims administration (FROI or SROI MTC 02);
2. Claim Administrator FEIN not due to change in claims administration (FROI or SROI MTC 02);
3. Claim Administrator Postal Code not due to change in claims administration (FROI or SROI MTC 02);
4. Claim Administrator Claim Number not due to change in claims administration (FROI or SROI MTC 02);
5. Industry Code (FROI MTC 02 only);
6. Manual Classification Code (FROI MTC 02 only);
7. Employee SSN (FROI or SROI MTC 02);
8. Employee ID Assigned by Jurisdiction (FROI or SROI MTC 02);
9. Employee First/Last Name, Last Name Suffix, Middle Name/Initial (FROI or SROI MTC 02);
10. Date of Injury (FROI or SROI MTC 02);
11. Employee Date of Death (FROI or SROI MTC 02).

(b) The claim administrator shall file MTC 02 (Change) to report a change in any other data element designated with the requirement code of “Y”, “Y[1]”, “Y[2]”, “Y[3]”, “Y[4]” or “FY” in the FROI or SROI MTC 02 column of the FL Claims EDI R3 Element Requirement Table contained in the FL Claims EDI Implementation Manual (e.g., Initial Date Disability Began, Benefit Payment Issue Date, etc.). The provision of Form DFS-F2-DWC-4 to the employee and employer is not required since these data elements are not contained on Form DFS-F2-DWC-4 adopted in Rules 69L-3.0091 and 69L-3.025, F.A.C.

(2) Electronic Notice of Action or Change in Claims Administration (MTC AQ, or MTC AU with applicable SROI MTC). If the responsibility for adjusting a “Lost Time/Indemnity Case”, “Medical Only to Lost Time Case” or “Denied Case” has changed due to acquisition of the claim from another claim administrator or due to the employer transferring a large deductible claim to the claim administrator because the claim met the contracted deductible threshold, the new claim administrator shall send FROI MTC AQ (Acquired Claim), to report the change in claims administration, on or before 21 days after the effective date of the new claim administrator’s acquisition of the claim. In place of filing FROI MTC AQ, the claim administrator may file FROI MTC AU (Acquired/Unallocated) with SROI MTC AP, EP, CD, VE, PY, or PD to report the change in claims administration. The claim administrator shall file FROI MTC AQ (Acquired Claim) or FROI MTC AU with applicable SROI MTC

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prior to sending any subsequent transactions (e.g., subsequent electronic suspension notices, electronic periodic claim cost reports, etc.).

(a) The acquiring claim administrator shall also provide to the employee and employer, Form DFS-F2-DWC-4 adopted in Rules 69L-3.0091 and 69L-3.025, F.A.C., or an explanatory letter, on or before 21 days from the date of acquisition, to advise the parties about the change in claims administration, except when sending Claims EDI filings identified in subparagraphs 69L-56.304(2)(c)6.-7., below.

(b) A batch of FROI MTC AQ (Acquired Claim) filings or FROI AU with applicable SROI MTC filings to report a change in claims administration for multiple claims shall replace the former option of the claim administrator to otherwise file with the Division Form DFS-F2-DWC-49, Aggregate Claims Administration Change Report adopted in Rules 69L-3.0231 and 69L-3.025, F.A.C., in place of Form DFS-F2-DWC-4, Notice of Action/Change, for each affected claim.

(c) If the FROI MTC AQ (Acquired Claim) rejects because a First Report of Injury or Illness was not previously filed with the Division by the former claim administrator, the acquiring claim administrator shall file FROI MTC AU (Acquired/Unallocated) with the appropriate SROI MTC AP, EP, CD, VE, PY, PD, or 04 on or before 14 days after the FROI MTC AQ (Acquired Claim) was assigned an Application Acknowledgement Code "TR" (Transaction Rejected) as follows:

1. If the claim administrator is reporting its initial payment of indemnity benefits other than a lump sum payment/settlement for an acquired claim, the Electronic Notice of a Change in Claims Administration shall be represented by sending FROI MTC "AU" (Acquired/Unallocated) with SROI MTC "AP" (Acquired/Payment).

2. If the claim administrator is reporting its initial payment of indemnity benefits for a lump sum payment or settlement for an acquired claim, the Electronic Notice of a Change in Claims Administration shall be represented by sending FROI MTC AU (Acquired/Unallocated) with SROI MTC "PY" (Payment Report).

3. If the claim administrator is reporting the initial payment of indemnity benefits by the employer on an acquired claim (i.e., salary in lieu of compensation), the Electronic Notice of a Change in Claims Administration shall be represented by sending FROI MTC AU (Acquired/Unallocated) with SROI EP (Employer Paid).

4. If the claim administrator is reporting a Compensable Death, No Dependents/Payees on an acquired claim, the Electronic Notice of a Change in Claims Administration shall be represented by sending FROI MTC AU (Acquired/Unallocated) with SROI MTC CD (Compensable Death, No Dependents/Payees).

5. If the claim administrator is reporting a compensable Volunteer on an acquired claim, the Electronic Notice of a Change in Claims Administration shall be represented by sending FROI MTC AU (Acquired/Unallocated) with SROI MTC VE (Compensable Volunteer).

6. If the claim administrator is reporting a Partial (Indemnity Only) Denial on an acquired claim, the Electronic Notice of a Change in Claims Administration shall be represented by sending FROI MTC AU (Acquired/Unallocated) with SROI MTC PD (Partial Denial).

a. The claim administrator shall file an Electronic Notice of Denial with the Division by reporting the applicable Partial Denial Reason Code and Denial Reason Narrative on the same SROI MTC PD (Partial Denial).

b. In addition to filing the Electronic Notice of Denial with the Division, the claim administrator shall provide a paper copy of Form DFS-F2-DWC-12, Notice of Denial, adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., to the employer and employee, in accordance with the filing time period set out for Form DFS-F2-DWC-12 in Rule 69L-3.012, F.A.C.

7. If the claim administrator is reporting a Full Denial on an acquired claim where indemnity payments were previously paid prior to the full denial, the Electronic Notice of a Change in Claims Administration shall be represented by sending FROI MTC AU (Acquired/Unallocated) with SROI MTC 04 (Denial).

a. The claim administrator shall file an Electronic Notice of Denial with the Division by reporting the applicable Full Denial Reason Code(s) and Full Denial Effective Date on the SROI MTC 04 (Denial). The Denial Reason Narrative shall also be sent on the SROI MTC 04 (Denial) to supplement the Denial Reason Code(s).

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b. In addition to filing the Electronic Notice of Denial with the Division, the claim administrator shall provide a paper copy of Form DFS-F2-DWC-12, Notice of Denial, adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., to the employer and employee, in accordance with the filing time period set out for Form DFS-F2-DWC-12 in Rule 69L-3.012, F.A.C.

(d) If MTC AQ (Acquired Claim) rejects because a First Report of Injury or Illness was not previously filed with the Division by the former claim administrator, and the acquiring claim administrator is denying the entire claim where no indemnity payments have been made, the acquiring claim administrator shall file FROI MTC 04 (Denial) on or before 14 days after the FROI MTC AQ (Acquired Claim) was assigned an Application Acknowledgement Code "TR" (Transaction Rejected) as follows:

1. The claim administrator shall file an Electronic Notice of Denial with the Division by reporting the applicable Full Denial Reason Code(s) and Full Denial Effective Date on the FROI MTC 04 (Denial). The Denial Reason Narrative shall also be sent on the FROI MTC 04 (Denial) to supplement the Denial Reason Code(s).

2. In addition to filing the Electronic Notice of Denial with the Division, the claim administrator shall provide a paper copy of Form DFS-F2-DWC-12, Notice of Denial, adopted in Rules 69L-3.012 and 69L-3.025, F.A.C., to the employer and employee, in accordance with the filing time period set out for Form DFS-F2-DWC-12 in Rule 69L-3.012, F.A.C.

(3) Electronic Notice to Report Initial Payment (MTC IP) Following Prior Employer Paid benefits, Compensable Death with no Known Dependants/Payees, or Compensable Volunteer Filing. If the claim administrator makes its initial payment following the prior initial payment of salary in lieu of compensation (SROI MTC EP), or after the prior filing of a SROI MTC CD (Compensable Death), or after the prior filing of a SROI MTC VE (Compensable Volunteer), the claim administrator shall file a SROI MTC IP (Initial Payment) on or before 14 days after the date the claim administrator's initial payment was mailed to the employee. The claim administrator shall provide Form DFS-F2-DWC-4 adopted in Rules 69L-3.0091 and 69L-3.025, F.A.C., or explanatory letter to the employee and employer regarding the commencement of indemnity benefits by the claim administrator.

(4) Electronic Notice of Lump Sum Payment/Settlement (MTC PY). If an order is signed for a lump sum payment or settlement of indemnity benefits subsequent to the initial payment of indemnity benefits, i.e., an award, advance, stipulated agreement, or final settlement of indemnity benefits, the claim administrator shall file SROI MTC PY (Payment Report), on or before 14 days after the date the award/order was signed. The claim administrator shall report the applicable Lump Sum Payment/Settlement Code as defined in Section 6, Data Dictionary, of the IAIABC Claims EDI R3 Implementation Guide as follows: "SF" (Settlement Full) if both indemnity and medical benefits are settled; "SP" (Settlement Partial) if only indemnity but not medical benefits are settled; "AS" (Agreement Stipulated) if the lump sum payment is for a non-adjudicated amount; "AW" (Award) if the lump sum payment is for an adjudicated amount; or "AD" (Advance) if the lump sum payment is for benefits in advance of when they were due. If all Impairment Income benefits due are paid in one lump sum amount, regardless of the amount, the claim administrator shall file SROI MTC PY with Benefit Type Code 030 or 530, and report Lump Sum Payment/Settlement Code "AD" (Advance). The claim administrator is not required to file an Electronic Notice of Suspension SROI MTC S7 (Suspension, Benefits Exhausted) to report the conclusion of the payment of Impairment Income benefits when Impairment Income benefits are paid in one lump sum.

(a) The claim administrator shall also report the "Payment Issue Date" on the SROI MTC PY. The Payment Issue Date shall represent the date payment for the lump sum payment/settlement leaves the control of the claim administrator for delivery to the employee or the employee's representative, and shall not be sent as the date the check is requested, created, or issued in the claim administrator's system unless the check leaves the control of the claim administrator the same day it is requested, created, or issued for delivery to the employee or the employee's representative.

(b) The claim administrator shall provide Form DFS-F2-DWC-4, Notice of Action/Change, adopted in Rules 69L-3.0091 and 69L-3.025, F.A.C., to the employee and employer.

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(5) Electronic Notice to Report Employer Payment of Indemnity Benefits that is not the Initial Payment (MTC EP). If the employer pays an indemnity benefit(s) for the first time following payment of and suspension of all indemnity benefits by the claim administrator (e.g., when the employer elects to pay Impairment Income Benefits), the claim administrator shall file SROI MTC EP (Employer Paid) on or before 14 days after the date the claim administrator had knowledge of the payment of indemnity benefits by the employer. The provision of Form DFS-F2-DWC-4 to the employee and employer is not required.

(6) The filing of a FROI or SROI MTC 02 to report a change in Insurer FEIN, Claim Administrator FEIN, or Claim Administrator Postal Code and Claim Administrator Claim Number due to the establishment of a new or elimination of a claims office location or subsidiary entity within the insurer's organization does not negate the obligation of the trading partner (insurer or claim administrator) to file a revised "EDI Trading Partner Profile, DFS-F5-DWC-EDI-1 (1/01/2008), and if applicable, a revised "EDI Trading Partner Insurer/Claim Administrator ID List", DFS-F5-DWC-EDI-2 (10/01/2006), and if applicable, a revised "EDI Trading Partner Claim Administrator Address List", DFS-F5-DWC-EDI-2A (10/01/2006), pursuant to subsection 69L-56.300(2), F.A.C.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07, Amended 5-17-09.

69L-56.3045 Electronic Notice of Action or Change, Suspensions, and Reinstatement of Indemnity Benefits Required by Insurer's Secondary Implementation Schedule.

(SROI MTC 02, CA, CB, AB, S1-S8, P7, RB, ER as found in the IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer & Acknowledgement Detail Records, Release 3, January 1, 2009 Edition)

(1) Electronic Notice of Action or Change (SROI MTC 02). On or before the compliance date established in the insurer's Secondary Implementation Schedule set forth in paragraph 69L-56.300(3)(b), F.A.C., the insurer shall file an Electronic Notice of Action or Change for the reporting of changes to the information in paragraphs (1)(a) and (b) of this section. The claim administrator shall file the SROI MTC 02 (Change) on or before 14 days after the claim administrator has knowledge of the new or changed information. However, MTC 02 shall not be sent if a data element changes as a result of an event that requires the reporting of another MTC pursuant to the definition of Maintenance Type Code (MTC) in the Data Dictionary located in Section 6 of the IAIABC Claims EDI Release 3 Implementation Guide.

(a) The claim administrator shall file SROI MTC 02 (Change) and provide Form DFS-F2-DWC-4 unless otherwise noted in subparagraph 1.-10. below, to the employee and employer, pursuant to Rules 69L-3.0091 and 69L-3.025, F.A.C., if any of the following data elements are changed:

1. Date of Maximum Medical Improvement.
2. Permanent Impairment Percentage.
3. Initial Return to Work Date.
4. Current Return to Work Date.
5. Return to Work Type Code.
6. Physical Restrictions Indicator.
7. Permanent Impairment Minimum Payment Indicator – No DFS-F2-DWC-4 required.
8. Return to Work with Same Employer Indicator – No DFS-F2-DWC-4 required.
9. Suspension Effective Date.
10. Suspension Narrative – No DFS-F2-DWC-4 required.

(b) The claim administrator shall file SROI MTC 02 and provide Form DFS-F2-DWC-4 unless otherwise noted in subparagraph 1.-15. below, to the employee and employer, pursuant to Rules 69L-3.0091 and 69L-3.025, F.A.C., if any of the following data elements are changed and there is no resulting change to the Net Weekly Amount because the benefit type being paid will continue to be paid at the same statutory maximum weekly rate, or because the claim administrator is correcting a code, date or amount previously reported in error and the Net Weekly Amount is unchanged:

1. Average Wage.
2. Wage Effective Date.

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3. Calculated Weekly Compensation Amount.
4. Gross Weekly Amount – No DFS-F2-DWC-4 required.
5. Gross Weekly Amount Effective Date – No DFS-F2-DWC-4 required.
6. Net Weekly Amount Effective Date – No DFS-F2-DWC-4 required.
7. Benefit Adjustment Code.
8. Benefit Adjustment Start Date.
9. Benefit Adjustment End Date.
10. Benefit Credit Code.
11. Benefit Credit Start Date.
12. Benefit Credit End Date.
13. Benefit Redistribution Code.
14. Benefit Redistribution Amount.
15. Benefit Redistribution Start Date.
16. Benefit Redistribution End Date.

When the claim administrator is commencing or suspending redirection of a portion of the Net Weekly Amount to another party on the behalf of the employee or the employee's beneficiary due to a court ordered lien for child support, the claim administrator shall report Benefit Redistribution Code "H" that is being applied to a specific indemnity benefit type, and file SROI MTC 02 on or before 14 days after the date the claim administrator has knowledge that a portion of the net weekly amount should be redistributed to another party due to an income deduction order pursuant to Section 61.1301, F.S., or when the redistribution has ended.

(2) Electronic Change in Amount (MTC CA): If the Net Weekly Amount changes from the amount previously reported due to a revised Average Wage (e.g., wage statement, discontinuation of fringe benefits), or due to the application of a Benefit Adjustment Code or Benefit Credit Code specified in paragraph (2)(a) of this section, the claim administrator shall file a SROI MTC CA (Change in Benefit Amount) on or before 14 days after the date the claim administrator has knowledge that the Net Weekly Amount should be amended.

(a) When the claim administrator applies an adjustment or credit which reduces the Net Weekly Amount for a specific indemnity benefit type, the claim administrator shall report the Benefit Adjustment Code or Benefit Credit Code being applied to the specific indemnity benefit type, and file SROI MTC CA (Change in Amount) to report the change as follows:

1. Benefit Adjustment Codes –

a. "A" = Apportionment/Contribution. The weekly payment amount is reduced for shared or partial liability with another party.

b. "B" = Subrogation (Third Party Offset). The weekly payment amount is reduced for recovery from third party tort-feasor pursuant to Section 440.39(2), F.S.

c. "N" = Non-cooperation: Rehabilitation, Training, Education, and Medical. The weekly payment amount is reduced because the employee failed to accept training and education pursuant to Section 440.491(6)(b), F.S., for dates of accident prior to October 1, 2003, or the employee failed to timely cancel an independent medical examination pursuant to Section 440.13(5)(d), F.S.

d. "R" = Social Security Retirement. The weekly payment amount is reduced for retirement benefits paid under the Federal Old Age, Survivors, and Disability Insurance Act, pursuant to Section 440.15(9), F.S.

e. "S" = Social Security Disability. The weekly payment amount is reduced for disability benefits paid under the Federal Old Age, Survivors, and Disability Insurance Act, pursuant to Section 440.15(9), F.S.

f. "U" = Unemployment Compensation. The weekly payment amount is reduced for payment of unemployment compensation insurance benefits, pursuant to Section 440.15(10), F.S.

g. "V" = Safety Violation. The weekly payment amount is reduced for safety violation(s) pursuant to Section 440.09(5), F.S.

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h. "X" = Death Benefit Reduction (Dependent Change). The weekly payment amount is reduced because of a change in number or kind of dependents entitled to death benefits pursuant to Section 440.16, F.S.

2. Benefit Credit Codes –

a. "C" = Overpayment. The weekly payment amount is reduced for recoupment of benefits paid but not due.

b. "P" = Advance. The weekly payment amount is reduced for reimbursement of benefit payments advanced pursuant to Section 440.20(13), F.S.

(b) In addition to filing MTC CA with the Division, the claim administrator shall provide Form DFS-F2-DWC-4 to the employee and employer as required by Rules 69L-3.0091 and 69L-3.025, F.A.C.

(c) If the Net Weekly Amount is adjusted due to the application of a Social Security Offset, the claim administrator shall also send to the Division a completed Form DFS-F2-DWC-14, Request for Social Security Disability Benefit Information, adopted in Rules 69L-3.021 and 69L-3.025, F.A.C., at the same time the claim administrator sends the SROI MTC CA to report the change in the Net Weekly Amount.

(d) If the Net Weekly Amount changes due to a change in the type of indemnity benefits that are being paid, the claim administrator shall file MTC CB (Change in Benefits) required by subsection 69L-56.3045(3), F.A.C., to report a change in the Benefit Type Code (BTC) that results in a change in the Net Weekly Amount payable (e.g., when indemnity benefits change from BTC 050 (Temporary Total) to BTC 070 (Temporary Partial) or BTC 030 (Impairment Income) – The claim administrator shall not file MTC CA (Change in Amount) for this occurrence.

(e) MTC CA is not required to report subsequent changes in the Net Weekly Amount payable for BTC 070 (Temporary Partial) for interim or ongoing fluctuations in the weekly rate due to variations in the employee's weekly earnings, or to report subsequent changes to the Net Weekly Amount payable for BTC 030 (Impairment Income Benefits) due to changes in the employee's weekly work status.

(f) MTC CA is also not required to be filed if the Net Weekly Amount changes due to subsequent applications of varying weekly adjustment or credit amounts against BTC 070 (Temporary Partial) or BTC 030 (Impairment Income) benefits. MTC CA, however, shall be filed to report a change in the Net Weekly Amount due to the ending of an adjustment or credit against BTC 070 (Temporary Partial) or BTC 030 (Impairment Income) benefits.

(3) Electronic Change in Benefit Type (MTC CB): When an indemnity benefit type being paid changes and payments are being continued under a different indemnity benefit type without a break in continuity of payments, the claim administrator shall file a SROI MTC CB (Change in Benefit Type) on or before 14 days after the date the claim administrator has knowledge that the indemnity benefit type being paid should be changed.

(4)(a) Adding Concurrent Benefit (MTC AB): When Permanent Total Benefits (Benefit Type 020) are being paid, and Permanent Total Supplemental Benefits (Benefit Type Code 021) are initiated subsequent to the prior commencement of Permanent Total Benefits (Benefit Type Code 020), the claim administrator shall file SROI MTC AB (Add Concurrent Benefit Type) on or before 14 days after the date the claim administrator has knowledge that Permanent Total Supplemental Benefits (Benefit Type Code 021) should be commenced.

(b) In addition to filing MTC AB with the Division, the claim administrator shall provide Form DFS-F2-DWC-4 to the employee and employer as required by Rules 69L-3.0091 and 69L-3.025, F.A.C.

(5)(a) Electronic Suspension of all indemnity benefits (MTC S1-S8): When all indemnity benefits are suspended because the employee returned to work, or was medically released to return to work and the claim administrator does not anticipate paying further indemnity benefits of any kind, the claim administrator shall file with the Division SROI MTC S1 (Suspension, RTW, or Medically Determined/Qualified RTW) on or before 14 days after the date the claim administrator decided to suspend all indemnity benefits.

(b) When all indemnity benefits are suspended because the employee failed to report for an independent medical examination pursuant to Section 440.13(5)(d), F.S., or failed to report for an evaluation by an expert medical advisor appointed by a Judge of Compensation Claims pursuant to Section 440.13(9)(c), F.S., the claim administrator shall file with the Division SROI MTC S2 (Suspension, Medical Non-compliance) on or before 14 days after the date the claim administrator decided to suspend all indemnity benefits.

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(c) When all indemnity benefits are suspended because the employee failed to comply with one or more of the following statutory sections and rules, the claim administrator shall file with the Division SROI MTC S3 (Suspension, Administrative Non-compliance) on or before 14 days after the date the claim administrator decided to suspend all indemnity benefits:

1. Section 440.15(1)(e)3, F.S. (1994), which is incorporated herein by reference – Employee in Permanent Total status failed to attend vocational evaluation or testing.

2. Section 440.15(1)(f)2b, F.S. (1994), which is incorporated herein by reference – Employee in Permanent Total status failed to report or apply for Social Security benefits.

3. Section 440.15(2)(d), F.S. (1994), which is incorporated herein by reference – Employee in Temporary Total status failed or refused to complete and return the Form DFS-F2-DWC-19 adopted in Rules 69L-3.021 and 69L-3.025, F.A.C.

4. Section 440.15(7), F.S. (1994), which is incorporated herein by reference – Employee in Temporary Partial status failed or refused to complete and return the Form DFS-F2-DWC-19 adopted in Rules 69L-3.021 and 69L-3.025, F.A.C.

5. Section 440.15(6), F.S. (2003), which is incorporated herein by reference – Employee refused suitable employment.

6. Section 440.15(9), F.S. (2003), which is incorporated herein by reference – Employee failed or refused to sign and return the release for Social Security benefits earnings on Form DFS-F2-DWC-14, or unemployment compensation earnings on Form DFS-F2-DWC-30 adopted in Rule 69L-3.025, F.A.C.

7. Section 440.491(6)(b), F.S. (2003), which is incorporated herein by reference – Employee failed or refused to accept vocational training or education.

8. Section 440.15(4)(d), F.S. (2003), which is incorporated herein by reference – Employee in Temporary Partial status failed to notify the claims-handling entity of the establishment of earnings capacity within 5 business days of returning to work.

9. Section 440.15(4)(e), F.S. (2003), which is incorporated herein by reference – Employee in Temporary Partial status terminated from post-injury employment due to the employee's misconduct.

10. Section 440.105(7), F.S. (2003), which is incorporated herein by reference – Employee refused to sign and return the fraud statement.

(d) When all indemnity benefits are suspended because the employee died and there are no known or confirmed dependents to whom death benefits must be paid, or if the death was not compensable, the claim administrator shall file with the Division SROI MTC S4 (Suspension, Claimant Death) on or before 14 days after the date the claim administrator decided to suspend all indemnity benefits.

(e) When all indemnity benefits are suspended because the employee became an inmate of a public institution and there are no known or confirmed dependents to whom indemnity benefits must be paid, the claim administrator shall file with the Division SROI MTC S5 (Suspension, Incarceration) on or before 14 days from the date the claim administrator decided to suspend all indemnity benefits.

(f) When all indemnity benefits are suspended because the claim administrator's good faith repeated attempts to locate and send indemnity benefits to the employee have been unsuccessful; or the employee has no known address, representative or guardian to whom the claim administrator can send indemnity benefits; or indemnity benefits have been returned to the claim administrator indicating that the employee has moved and the current or forwarding address is unknown, or the employee no longer resides at the last known address, the claim administrator shall file with the Division SROI MTC S6 (Suspension, Claimant's Whereabouts Unknown) on or before 14 days after the date the claim administrator decided to suspend all indemnity benefits.

(g) When all indemnity benefits are suspended because the employee is no longer eligible for or entitled to any indemnity benefits because the limits of or entitlement to indemnity benefits have been exhausted, the claim administrator shall file with the Division SROI MTC S7 (Suspension, Benefits Exhausted) on or before 14 days after the date the claim administrator decided to suspend all indemnity benefits.

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(h) When all indemnity benefits are suspended because the employee elects to receive workers' compensation benefits under another state's law, or the claim administrator determines the claim is compensable under another compensation act, such as the Federal Employers' Liability Act, the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act, or the Jones Act, the claim administrator shall file with the Division SROI MTC S8 (Suspension, Jurisdiction Change) on or before 14 days after the date the claim administrator decided to suspend all indemnity benefits. Until the claim administrator implements the electronic reporting of suspension information as required in Rules 69L-56.304 and 69L-56.3045, F.A.C., the claim administrator shall file Form DFS-F2-DWC-4, Notice of Action/Change adopted in Rules 69L-3.0091 and 69L-3.025, F.A.C., and report Suspension Reason Code "S8" when there is a change in jurisdiction; however, once the claim administrator is in production status with filing electronic suspension notices, the claim administrator shall report a change in jurisdiction by filing SROI MTC S8 (Suspension, Jurisdiction Change).

(i) In addition to filing MTC SROI S1-S8 with the Division, the claim administrator shall provide Form DFS-F2-DWC-4 to the employee and employer as required by Rules 69L-3.0091 and 69L-3.025, F.A.C.

(j) When Permanent Total Supplemental Benefits (Benefit Type 021) are suspended but Permanent Total Benefits (Benefit Type 020) will continue to be paid, the claim administrator shall file with the Division SROI MTC P7 (Partial Suspension, Benefits Exhausted) on or before 14 days after the date Permanent Total Supplemental Benefits were suspended. In addition to filing MTC P7 with the Division, the claim administrator shall provide Form DFS-F2-DWC-4 to the employee and employer as required by Rules 69L-3.0091 and 69L-3.025, F.A.C.

(6) Electronic Reinstatement of Indemnity Benefits (MTC RB, ER):

(a) When payment of indemnity benefits are resumed by the claim administrator after having been previously suspended, the claim administrator shall file with the Division a SROI MTC RB (Reinstatement of Benefits) on or before 14 days after the date the claim administrator had knowledge of the need to reinstate indemnity benefits. In addition to filing SROI MTC RB with the Division, the claim administrator shall provide Form DFS-F2-DWC-4 to the employee and employer as required by Rules 69L-3.0091 and 69L-3.025, F.A.C.

(b) When the employer reinstates payment of salary in lieu of compensation following a prior suspension of all indemnity benefits paid by the employer, the claim administrator shall file with the Division SROI MTC ER (Employer Reinstatement) on or before 14 days after the date the claim administrator received notification about the reinstatement of salary in lieu of compensation. Form DFS-F2-DWC-4 is not required to be sent to the employee or employer.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07, Amended 5-17-09.

69L-56.307 Electronic Cancellation of Claim.

(FROI MTC 01 as found in the IAIABC Implementation Guide for Claims: First, Subsequent, Header, Trailer and Acknowledgement Detail Records, Release 3, January 1, 2009 Edition)

(1) The claim administrator shall send FROI MTC 01 (Cancel) immediately upon the claim administrator's knowledge of the need to cancel if any of the following occur:

(a) An Electronic First Report of Injury or Illness was accepted by the Division and the claim administrator subsequently determined the claim was filed in error because it was actually a Medical Only Case. The FROI MTC 01 shall reflect the Claim Type as "B" (Became Medical Only).

(b) An Electronic First Report of Injury or Illness was accepted by the Division and the claim administrator subsequently determined the claim was filed with inaccurate identifying information and was a duplicate of another accepted claim.

(2) If a claim has been cancelled via FROI MTC 01 (Cancel) after an Electronic First Report of Injury or Illness was previously filed with the Division and the claim administrator determines the claim should not be cancelled after all, the claim administrator shall re-file a subsequent Electronic First Report of Injury or Illness using the applicable MTC(s) specified in this rule for reporting an Electronic First Report of Injury or Illness. The original Electronic First Report of Injury or Illness sent to the Division shall be disregarded and considered not filed with the

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Division. The due date for filing the subsequent Electronic First Report of Injury or Illness shall correspond to the filing timeframes specified in this rule for the applicable MTC(s) required for an Electronic First Report of Injury. If un-canceling a claim to file a full or partial denial of indemnity benefits, the claim administrator shall provide to the employee and employer, Form DFS-F2-DWC-12 adopted in Rules 69L-3.012 and 69L-3.025, F.A.C.

Rulemaking Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07, Amended 5-17-09.

69L-56.310 Technical Requirements for Claims EDI Transmissions.

(1) Insurers shall send Claims EDI Filings required in Rules 69L-56.301, 69L-56.3012, 69L-56.3013, 69L-56.304, 69L-56.3045, 69L-56.307 and 69L-56.330, F.A.C., to the Division using only the following transmission methods:

(a) Advantis Value Added Network (VAN), or

(b) Secure Socket Layer/File Transfer Protocol (SSL/FTP) in accordance with instructions on Form DFS-F5-DWC-EDI-4 (1/01/2008).

(2) Electronic transmissions of Claims EDI Filings shall be sent to the Division using the First Report of Injury (FROI)/148 flat file transaction set, including the R21 companion record, and the Subsequent Report (SROI)/A49 flat file transaction set, including the R22 companion record, described in Section 2, "Technical Documentation", of the IAIABC Claims EDI Release 3 Implementation Guide. The claim administrator shall not send transmissions containing files in the ANSI 148 format to the Division.

(3)(a) Each FROI transmission shall contain at least one batch in the FROI format, a sample of which is located in Section 2, Technical Documentation, in the IAIABC Claims EDI Release 3 Implementation Guide. Each SROI transmission shall contain at least one batch in the SROI format located in Section 2, Technical Documentation, Record Layouts, in the IAIABC Claims EDI Release 3 Implementation Guide.

(b) Each batch shall contain only one of the following transaction types:

1. First Report of Injury (FROI/148 transaction with R21 companion record), or

2. Subsequent Report of Injury (SROI/A49 transaction with R22 companion record).

(c) A batch shall contain the following as set forth in Section 2, Technical Documentation, in the IAIABC Claims EDI Release 3 Implementation Guide:

1. Header Record,

2. One or more transactions – FROI 148 with R21, or SROI A49 with R22,

3. Trailer Record.

(d) Header records shall include the following information:

1. Receiver FEIN for the State of Florida: 596001874,

2. Receiver Postal Code for the State of Florida: 323994226,

3. Sender Identifier. The Sender Identifier (Sender ID) shall consist of the claim administrator's FEIN and Postal Code as reported on Form DFS-F5-DWC-EDI-3 (10/01/2006), EDI Transmission Profile – Sender's Specifications.

(4) To report the electronic equivalent of the First Report of Injury or Illness (Form DFS-F2-DWC-1 adopted in Rules 69L-3.0045 and 69L-3.025, F.A.C.), where total compensability of the claim has not been denied, the claim administrator shall send to the Division both the FROI and SROI within the processing times set out in subsection (5) of this section. If either the FROI or SROI contains an error that results in the rejection of one of the transactions, both the FROI and SROI shall be rejected and the claim administrator shall re-send both the corrected FROI and SROI to the Division within the processing times set out in subsection (5) of this rule section, in order for the two transactions to be processed together. The Division will only pair for processing purposes, FROI's and SROI's that are received by the Division on the same day, as set out in subsection (5) of this rule section.

(5) Transmissions received on or before 9:00 p.m., Eastern Standard Time, shall be processed by the Division the same day the transmission was sent to the Division and acknowledged by the Division the next day. Transmissions received after 9:00 p.m. through 11:59 p.m., Eastern Standard Time, shall be processed by the

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Division the following day and acknowledged by the Division the next day after the transmission is processed.

(6) During the test phases, the "Test-Production Code" in the Header record shall be set to "T". After the claim administrator has been approved by the Division to send transmissions in production status, the "Test-Production Code" shall be set to "P".

(7) The claim administrator shall have the capability to receive and process the Division's Claims EDI AKC Acknowledgement transaction described in Section 2, Technical Documentation, of the IAIABC Claims EDI Release 3 Implementation Guide. The claim administrator shall update its database with the Jurisdiction Claim Number (JCN) provided by the Division on the EDI AKC Acknowledgement transaction for each successfully filed transaction.

(8) Formats and meaning of data elements reported via EDI to the Division pursuant to this rule shall match format specifications and data element definitions established in Sections 2, 4 and 6 of the IAIABC Claims EDI Release 3 Implementation Guide, unless otherwise defined in Rule 69L-56.002, F.A.C.

(9) The claim administrator's business and technical contacts shall have e-mail system capabilities that support Word, Excel, or PDF attachments from the Division of at least 2 Megabytes.

(10) The claim administrator or other third party vendor shall utilize anti-virus software to screen out and clean any viruses on all electronic transmissions prior to sending transmissions to the Division. The claim administrator or other third party vendor shall maintain anti-virus software with the most recent anti-virus update files from the software provider. If the claim administrator or third party vendor sends a transmission that contains a virus which prevents the Division from processing the transmission, the transmission will not be considered as having been received by the Division.

(11) If a vendor is submitting files on behalf of more than one insurer or claim administrator, the vendor shall send separate header and trailer records for each claim administrator. The Sender ID on the Header Record shall represent the insurer's or claim administrator's FEIN and Postal Code, not that of the vendor.

Rulemaking Authority 440.591, 440.593 FS. Law Implemented 440.593 FS. History–New 5-29-05, Amended 1-7-07, 5-17-09.

69L-56.320 Claims EDI Test and Production Status Requirements.

(1) Prior to sending an initial test transmission, the claim administrator shall file the EDI Trading Partner forms required in subsection 69L-56.300(2), F.A.C. If a form is incomplete and does not contain responses to all of the required fields in accordance with the form instructions, testing with the Division will not commence until the corrected form(s) is re-filed with the Division.

(2) If the claim administrator has contracted with a vendor to send Claims EDI filings on its behalf to the Division, the claim administrator shall comply with the testing requirements in this section before being approved for production status, even if the vendor has been previously approved by the Division for production status with another client.

(3) During the Claims EDI testing period and until the claim administrator is approved for production status for sending the required electronic form equivalents required by this rule, the claim administrator shall continue to file Forms DFS-F2-DWC-1, DFS-F2-DWC-12, DFS-F2-DWC-13 and DFS-F2-DWC-4 and DFS-F2-DWC-49 in accordance with Rules 69L-3.0045, 69L-3.0091, 69L-3.012, 69L-3.016, 69L-3.0213 and 69L-3.025, F.A.C.

(4) The claim administrator shall send test files in the correct IAIABC Release 3 formats specified in Section 2, Technical Documentation, of the IAIABC Claims EDI Release 3 Implementation Guide, and comply with transmission requirements set out in Rule 69L-56.310, F.AC.

(5) The insurer or claim administrator shall indicate the Maintenance Type Codes (MTC's) it will be sending, if not all MTC's will be initially tested at the same time (e.g., MTC's not required until the insurer's Secondary Implementation Schedule). The claim administrator shall file a revised Form DFS-F5-DWC-EDI-3, EDI Transmission Profile – Sender Specifications, to report any new MTC's that will be added during the test to production periods.

(6) The claim administrator shall also indicate on its Form DFS-F5-DWC-EDI-3, Transmission Profile – Sender Specifications, the frequency with which files will be sent to the Division, i.e., daily, weekly. Test files shall consist

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of Claims EDI Filings that correspond with Forms DFS-F2-DWC-1, DFS-F2-DWC-12, DFS-F2-DWC-13, and DFS-F2-DWC-4 adopted in Rules 69L-3.025, F.A.C., that were previously mailed to the Division at least one week prior to the date the test transmission containing the corresponding Electronic First Report of Injury or Illness, Electronic Notice of Denial, Electronic Periodic Claim Cost Report, and Electronic Notice of Action or Change, Suspension, and Reinstatement of Indemnity Benefits information is sent to the Division. If the claim administrator is unable to transmit test files on a daily or weekly basis due to a low volume of actual claim filings being mailed to the Division during the specified testing frequency, the claim administrator may create and send "mock" paper and electronic filings for Claims EDI testing purposes. The claim administrator shall clearly mark any mock paper filings as an "EDI Test Filing" and fax the mock paper filings to the Division's Claims EDI Team at (850) 488-3453.

(7) Data element values sent on the test Claims EDI filings shall match values reported on the corresponding paper form filing. If differences are detected and cited in a written parallel analysis report issued to the claim administrator by the Division, the claim administrator shall confirm if the electronic version contained the accurate data, or otherwise provide an explanation for the discrepancy. The claim administrator shall investigate and reconcile its database as necessary in conjunction with data errors identified during the test period(s).

(8) The claim administrator shall send the following minimum number of Claims EDI filings during the test period(s), of which 90% of each of the required categories specified in paragraphs (5)(a) through (f) of this section shall receive an Application Acknowledgement Code of "TA":

(a) Ten (10) Electronic First Report of Injury or Illness filings utilizing at least two of each of the following required FROI/SROI MTC combinations: 00/IP, 00/EP, and 00/PY. MTC's 00/CD, 00/VE, and AU/AP may be optionally included in the testing period. The claim administrator shall send one of the two required MTC 00/IP filings with Claim Type "I" and the other required MTC 00/IP filing with Claim Type "L".

(b) Five (5) Electronic Denied First Report of Injury or Illness filings utilizing at least one FROI MTC 04 (Full Denial) and one FROI MTC 00 with SROI PD (Partial Denial). The Electronic First Report of Injury or Illness shall include the applicable Full Denial Reason Code(s) and Partial Denial Code with Denial Reason Narrative, to report the Electronic Notice of Denial information.

(c) Ten (10) Electronic Periodic Claim Cost filings utilizing at least two each of the following SROI MTC's: SA or FN. A corresponding paper or Electronic First Report of Injury or Illness must have been previously accepted in test or production status before testing MTC SA or FN.

(d) Five (5) Electronic Notice of Denial filings (post-EDI DWC-1) utilizing at least one each of the following SROI MTC's: MTC 04 and PD (Electronic First Report of Injury or Illness must have been previously accepted in test or production status before testing these EDI filings.)

(e) Five (5) Electronic Notice of Action or Change transactions based on electronic filings required in the insurer's Primary Implementation Schedule for the initial testing period if not all MTC's will be implemented by the insurer during its Primary Implementation Schedule, utilizing either FROI or SROI MTC 02 (Change). A corresponding paper or Electronic First Report of Injury or Illness must have been previously accepted in test or production status before testing these EDI filings with the Division.

(f) Five (5) of the following Electronic Notice of Action or Changes, Suspension and Reinstatement of Indemnity Benefits filings required in the insurer's Secondary Implementation Schedule utilizing at least two MTC 02 filings, one of which shall report a change in the Average Wage with no change to the Net Weekly Amount and one MTC 02 that reports a Benefit Redistribution. The claim administrator shall also send at least one each of the following MTC's: S1-S8 (Suspensions); RB (Reinstatement); CA (Change in Amount), CB (Change in Benefit Type).

(9) To be approved for production status:

(a) The claim administrator shall achieve a 90% acceptance rate for Claims EDI Filings sent during the test period(s), i.e., 90% of all test Claims EDI Filings shall be accepted and assigned an Application Acknowledgement Code "TA" (Transaction Accepted), and 10% or less of all Claims EDI filings shall be assigned an Application Acknowledgement Code "TR" (Transaction Rejected); and,

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(b) The claim administrator must achieve a 95% accuracy rate for correctly reporting the following data elements:

1. Benefit Payment Issue Date and Payment Issue Date (represents the date payment was mailed to the employee); and

2. Employee SSN and Date of Injury (unless Form DFS-FS-DWC-4, Notice of Action/Change adopted in Rules 69L-3.0091 and 69L-3.025, F.A.C., was filed to report a change in Employee SSN and Date of Injury that explains the different value sent on the test EDI filing compared to the value sent on the prior paper or EDI filing); and

3. Benefit Type reported on the Division paper form promulgated under Rules 69L-3.0045, 69L-3.0091, 69L-3.012, 69L-3.016 and 69L-3.025, F.A.C., compared to the test Electronic First Report of Injury or Illness filing; and

4. Initial Date of Lost Time; and

5. Date Claim Administrator Had Knowledge of Lost Time; and

6. Any penalties and/or Interest reported on the prior paper filing compared to the test Electronic First Report of Injury or Illness, and

(c) The claim administrator has responded to all parallel pilot analysis reports issued during the test period(s).

(10) The claim administrator shall send a minimum of two transmissions containing the test MTC's pursuant to subsection (8) of this section for evaluation by the Division before the claim administrator will be approved for production status.

Specific Authority 440.591, 440.593(5) FS. Law Implemented 440.593 FS. History–New 1-7-07.

69L-56.500 Insurer Responsibilities Where Third Party Services Are Utilized.

If an insurer contracts with a claim administrator or third party vendor to electronically send transactions to the Division on the insurer's behalf, or uses a claim administrator or third party vendor's software product for electronically sending transactions to the Division, the insurer shall remain responsible for the timely filing of transactions required by this rule, processing of acknowledgements, and any penalties and fines that may result from untimely electronic filings.

Specific Authority 440.591, 440.593(5) FS. Law Implemented 440.20(8)(b), 440.593 FS. History–New 5-29-05, Amended 1-7-07.

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