

Florida Division of Workers' Compensation
Medical Data Management

**Scenarios for Electronically Filing Medical Reconsideration Bills
within the Division of Workers' Compensation's Medical Data System**

There are **four primary scenarios** that will result in "reconsideration medical bills" being submitted to the Division of Workers' Compensation. Please be reminded that each accepted bill must be paid, adjusted and paid, disallowed or denied within 45 calendar days of insurer receipt pursuant to s. 440.20 (2) (b) Florida Statute, and that each accepted bill must be electronically filed with the division within 45 calendar days of insurer payment, adjustment and payment, disallowance or denial pursuant to the Medical Billing, Filing, and Reporting Rule, 69L-7.602, Florida Administrative Code. These scenarios apply to all medical only and all lost time medical bills.

Scenario 1: The insurer denies payment on an entire bill, or disallows or denies one or more line items on the bill, the provider submits a reconsideration bill requesting payment for those line items previously disallowed or denied, and the original bill has been previously filed with the division.

Scenario 2: The insurer adjusts and pays one or more line items. The provider submits a reconsideration bill with supporting documentation for payment of original charged amount (s) of the original line item(s).

Scenario 3: The insurer adjusts and pays a bill and submits the original bill to the division. The provider subsequently submits a reconsideration bill to the insurer including one or more additional line items relating to the original bill.

Scenario 4: The insurer reports the original bill to the division and it is accepted. The insurer subsequently discovers an error in the reported data that requires submission of a corrected bill to the division.

Each of these situations (and there may be more added to this list as we encounter them) requires unique handling to assure the data are properly reported to the Division of Workers' Compensation, as follows:

Scenario 1: The insurer denies payment on an entire bill, or disallows or denies one or more line items on the bill, the provider submits a reconsideration bill requesting payment for those line items previously disallowed or denied, and the original bill has been previously filed with the division.

In this scenario, when the reconsideration issue is resolved with the provider, generate a brand new control number for this reconsidered bill, and report *only* the line items that are being reconsidered (the ones that were previously disallowed or denied) within 45 calendar days of payment, adjustment and payment, disallowance or denial; report the date the *reconsidered bill* was received from the provider in the "Date Insurer Received Bill From Provider" field and the *new* adjudicated date in the "Date Insurer Paid, Adjusted and Paid,

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Disallowed or Denied Bill" field. Both the original bill and the reconsidered bill should be submitted with a Report Reason Code of "00" (Original Submission).

Scenario 2: The insurer adjusts and pays one or more line items. The provider submits a reconsideration bill with supporting documentation for payment of the original charged amount(s) for the original line item(s), and the original bill has been previously filed with the division.

In this scenario, the original bill has been electronically filed with the division within 45 calendar days of payment, adjustment and payment, disallowance or denial. When the reconsideration bill is received from the provider and paid by the insurer, submit a replacement bill, with a Report Reason Code of "03" (Replacement Report), to the division with the same control number used in the original submission. Include *all* of the original line items, reporting the *new* paid amounts (or any other data that have been changed) for those line items affected by the reconsideration, within 45 calendar days of receiving the reconsideration bill from the provider. The new paid amount must reflect the full amount paid to the provider for each line item – namely, the original amount plus the additional amount combined. Please report the received date of the *original bill* in the "Date Insurer Received Bill From Provider" field and the *original* paid date in the "Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill" field. This replacement bill submission will allow a "final" version of the paid bill to be placed in the division's medical database, without resulting in duplicate line item amounts that would erroneously offset the actual payment data.

Scenario 3: The insurer adjusts and pays a bill and submits the original bill to the division. The provider subsequently submits a reconsideration bill to the insurer including one or more additional line items relating to the original bill.

This scenario is handled similar to the first scenario. The original bill has been electronically filed with the division within 45 calendar days of payment, adjustment and payment, disallowance or denial. When the reconsideration bill is received from the provider reflecting the additional line items, generate a brand new control number for this reconsidered bill, and report *only* the additional line items within 45 calendar days of payment, adjustment and payment, disallowance or denial; report the date the *reconsideration bill* was received from the provider in the "Date Insurer Received Bill From Provider" field and the *new* payment date in the "Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill" field. Both the original bill and the reconsidered bill should be submitted with a Report Reason Code of "00" (Original Submission).

Scenario 4: The insurer reports the original bill to the division and it is accepted. The insurer subsequently discovers an error in the reported data that requires submission of a corrected bill to the division.

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This scenario is handled similar to the second scenario. The original bill has been electronically filed with the division within 45 calendar days of payment, adjustment and payment, disallowance or denial. Subsequently, an error in reported data is discovered. Make appropriate corrections to the data and submit a replacement bill with a Report Reason Code of "03" (Replacement Report) to the division using the same control number(s) as the original bill. Report the corrected bill data, including ALL the line items, even if only one or two items are being corrected. Report the date the *original bill* was received from the provider in the "Date Insurer Received Bill From Provider" field and the *original* paid date in the "Date Insurer Paid, Adjusted and Paid, Disallowed or Denied Bill" field.

To summarize, consider the following when handling these scenarios:

If a line item does not exist on the original bill that was reported to the division and accepted into the DWC database, or a line item was previously denied or disallowed on the original bill, submit a *new* bill with a *new* control number (Report Reason 00), including *only* the new line items and/or line items previously denied or disallowed.

If a line item being reconsidered has already been reported to the division and accepted into the DWC database, then the updated data for that line item needs to REPLACE the original line item stored in the database. Therefore, the reconsidered bill must be reported as a Replacement (Report Reason 03), including *all* the line items and using the same control number as the original bill.