Department of Financial Services
Division of Workers’ Compensation
Wednesday, August 26, 2015
Regulatory and Legislative Update

Andrew Sabolic
Assistant Director
Hospital Reimbursement Manual

• All compensable charges for hospital outpatient care shall be reimbursed at 75% of usual and customary charges – s. 440.13(12)(a)
• Outpatient reimbursement for scheduled surgeries is 60% of charges – s. 440.13(12)(b)3
• The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates – s. 440.13(12)(a)
• New manual became effective on 1/1/15; -0.8% cost savings or -$26 million
### Hospital Reimbursement Manual (Outpatient Services)

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual &amp; Customary (U&amp;C) charge = hospital’s charge multiplied by .75 or .60 depending on whether the procedure was associated with a scheduled surgery</td>
<td>U&amp;C charge = statewide average charge per qualifying procedure, multiplied by .75 or .60 depending on whether the procedure was associated with a scheduled surgery; apply Medicare geographic wage adjustment factor based upon location of service to attain MRA for procedure</td>
</tr>
<tr>
<td>7 years of development, numerous U&amp;C calculation methodologies, and rule challenges</td>
<td>354 procedures are subject to an MRA at 75% of U&amp;C charges</td>
</tr>
<tr>
<td></td>
<td>192 procedures are subject to an MRA at 60% of U&amp;C charges</td>
</tr>
<tr>
<td></td>
<td>Approximately 68% of all WC hospital outpatient charges will be subject to payment at the MRAs</td>
</tr>
<tr>
<td></td>
<td>Procedures not subject to an MRA are reimbursed 75% or 60% of the hospital’s charges</td>
</tr>
</tbody>
</table>
### Hospital Reimbursement Manual

**Inpatient Services**

#### 2006 Edition of the Hospital R.M.

<table>
<thead>
<tr>
<th>Trauma center per diem rates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical stay = $3,305</td>
</tr>
<tr>
<td>Non-surgical stay = $1,986</td>
</tr>
</tbody>
</table>

#### 2014 Edition of the Hospital R.M.

<table>
<thead>
<tr>
<th>Trauma center per diem rates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical stay = $3,805.33</td>
</tr>
<tr>
<td>Non-surgical stay = $2,313.69</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute care hospital per-diem rates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical stay = $3,304</td>
</tr>
<tr>
<td>Non-surgical stay = $1,960</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Acute care hospital per-diem rates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical stay = $3,849.16</td>
</tr>
<tr>
<td>Non-surgical stay = $2,283.40</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stop-loss reimbursement threshold after implant carve out = $51,4000</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Stop-loss reimbursement threshold after implant carve out = $59,891.34</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Bills that exceed that stop-loss threshold are reimbursed at 75% of the hospital’s charges</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Bills that exceed that stop-loss threshold are reimbursed at 75% of the hospital’s charges</th>
</tr>
</thead>
</table>
Effective on January 1, 2016
- Increases the number of procedures subject to an MRA from 28 to 92
- MRAs are calculated based upon 60% of the average charges of ASCs, instead of 70%
- Procedures not subject to an MRA are reimbursed 60% of the ASC’s charge, instead of 70%
- Eliminated multiple procedure discounts
- -0.1% cost savings, or -$3 million
Adopted, but **NOT IN EFFECT**, pending legislative ratification

Utilizes 2014 Medicare Rates to establish MRAs (2008 Medicare Rates are still currently in effect)

+1.9% cost increase, or $61 million
Legislation to Exempt Reimbursement Manual from Ratification

- In 2010, the Legislature enacted changes to Chapter 120, the Administrative Procedure Act. These changes require each state agency to submit for legislative ratification any rule that meets one or more of the following criteria:
  1. The rule is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;
  2. The rule is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or
  3. The rule is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

- SB 1060 passed unanimously; HB 1013 died in committee
2016 Legislative Proposals

- Exempt reimbursement manuals from legislative ratification and, or seek specific legislative ratification bill for HCP Manual
- Revisions to employer compliance penalties
- Allow JCCs to independently appoint EMAs
- Allow revocations of election of coverage and election to be exempt to be filed electronically
- Repeal requirement to telephonically report death claims within 24 hours
- Eliminate SDTF filing fees and new carrier registration fees
Under the Radar Success Stories

• Bureau of Compliance – Mex Group Case (underreporting of payroll); Employer Outreach Campaign; POC Mobile App; Check Cashing Store Database

• WCATF and SDTF Assessment Rate Reductions

• SDTF Reimbursements – 60 to 75 days from reimbursement request to payment

• Customized educational & training programs – Claims EDI Triage; SI Payroll and Classification Webinars; Claims Adjuster Training (on-site & videos)
What Are Injured Workers Telling Us?

Stephen Yon
Bureau of Employee Assistance & Ombudsman Office
Bureau of Employee Assistance and Ombudsman Office

- Investigates disputes and facilitates resolution without undue expense, costly litigation, or delay in the provision of benefits.
- Assists system participants in fulfilling their statutory responsibilities.
- Educates and disseminates information to all system participants.
Bureau of Employee Assistance and Ombudsman Office

- Initiates contacts with injured workers to discuss their rights and responsibilities and advise them of services available through EAO.
- Reviews claims in which injured workers' benefits have been denied, stopped, or suspended.
- Provides reemployment services to eligible injured employees who are unable to return to work as a result of their work place injuries or illnesses.
First Report of Injury Team

- EAO noticed some concerning trends
- Identified indicators of future litigation
- Team was established in April/May 2007
- Initiate contact with injured workers early in their claim
  - Generally 18-20 days after date of accident
First Report of Injury Team

• Who do we attempt to contact?

  ▪ Lost time claims reported to the Division
    Excluding:
      ▪ Denied Claims
      ▪ Policemen and Firefighters
First Report of Injury Team

• Why do we call?
  ▪ Provide education
  ▪ Identify issues
  ▪ Survey injured workers
  ▪ Market services of EAO
  ▪ Avoidance of Future Litigation
Survey Questions

- Telephone contact by the DWC-1 Team
- Do you have the name and telephone number of your insurance company?
- Has the insurance company provided you with any information regarding your workers’ compensation claim?
- Are you receiving authorized medical care for your injury?
Survey Questions

• As of today do you feel you have received adequate medical treatment for your injury?
  ▪ If no, what are your particular concerns?
• Have you returned to work?
• Have you been in contact with your employer since your date of injury?
• Have you received your first benefit check (if applicable)?
• Do you have any additional questions?
### Injured Worker Survey

<table>
<thead>
<tr>
<th>Contact Results</th>
<th>Petition for Benefit Filed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Carriers</strong></td>
<td><strong>Carrier-</strong></td>
</tr>
<tr>
<td>Count (%)</td>
<td>Count (%)</td>
</tr>
</tbody>
</table>

| RESPONSE NOT AVAILABLE | 274 | 15 | 81 | 5 |

| YES | 26,457 | 1,385 | 3,534 | 179 |
|     | (96.33%) | (95.52%) | (13.36%) | (12.92%) |

| NO  | 1,008 | 65   | 319   | 11 |
|     | (3.67%) | (4.48%) | (31.65%) | (16.92%) |

5. As of today, do you think you have received adequate medical treatment for your injury?
## Injured Worker Survey

<table>
<thead>
<tr>
<th>If No, what are your specific concerns?</th>
<th>Contact Results</th>
<th>Petition for Benefit Filed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Carriers</td>
<td>Carrier-</td>
</tr>
<tr>
<td></td>
<td>Count (%)</td>
<td>Count (%)</td>
</tr>
<tr>
<td>MEDICAL REFERRALS</td>
<td>496 (49.21%)</td>
<td>28 (43.08%)</td>
</tr>
<tr>
<td></td>
<td>158 (31.85%)</td>
<td>4 (14.29%)</td>
</tr>
<tr>
<td>SURGERY</td>
<td>82 (8.13%)</td>
<td>6 (9.23%)</td>
</tr>
<tr>
<td></td>
<td>23 (28.05%)</td>
<td>1 (16.67%)</td>
</tr>
<tr>
<td>PHYSICAL THERAPY</td>
<td>92 (9.13%)</td>
<td>40 (43.48%)</td>
</tr>
<tr>
<td></td>
<td>5 (7.69%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>PRESCRIPTION</td>
<td>72 (7.14%)</td>
<td>26 (36.11%)</td>
</tr>
<tr>
<td></td>
<td>7 (10.77%)</td>
<td>3 (42.86%)</td>
</tr>
<tr>
<td>TESTS</td>
<td>89 (8.83%)</td>
<td>21 (23.65%)</td>
</tr>
<tr>
<td></td>
<td>9 (13.85%)</td>
<td>1 (11.11%)</td>
</tr>
<tr>
<td>OTHER</td>
<td>177 (17.56%)</td>
<td>51 (28.81%)</td>
</tr>
<tr>
<td></td>
<td>10 (15.38%)</td>
<td>2 (20%)</td>
</tr>
</tbody>
</table>
Injured Worker Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Contact Results</th>
<th>Petition for Benefit Filed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Carriers</td>
<td>Carrier-</td>
</tr>
<tr>
<td>Count (%)</td>
<td>Count (%)</td>
<td>Count (%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Have you been in contact with your employer since your date of injury?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESPONSE NOT AVAILABLE</td>
<td>298</td>
<td>14</td>
</tr>
<tr>
<td>YES</td>
<td>27,277 (99.4%)</td>
<td>1,445 (99.59%)</td>
</tr>
<tr>
<td>NO</td>
<td>164 (0.6%)</td>
<td>6 (0.41%)</td>
</tr>
</tbody>
</table>
### Injured Worker Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>All Carriers</th>
<th>Carrier-</th>
<th>All Carriers</th>
<th>Carrier-</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Have you received your first benefit check (If applicable)?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESPONSE NOT AVAILABLE</td>
<td>1,293</td>
<td>68</td>
<td>252</td>
<td>11</td>
</tr>
<tr>
<td>YES</td>
<td>10,712</td>
<td>530</td>
<td>1,539</td>
<td>73</td>
</tr>
<tr>
<td>(40.51%)</td>
<td>(37.94%)</td>
<td>(14.37%)</td>
<td>(13.77%)</td>
<td></td>
</tr>
<tr>
<td>NOT APPLICABLE</td>
<td>15,329</td>
<td>841</td>
<td>2,060</td>
<td>108</td>
</tr>
<tr>
<td>(57.96%)</td>
<td>(60.2%)</td>
<td>(13.44%)</td>
<td>(12.84%)</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>405</td>
<td>26</td>
<td>83</td>
<td>3</td>
</tr>
<tr>
<td>(1.53%)</td>
<td>(1.86%)</td>
<td>(20.46%)</td>
<td>(11.54%)</td>
<td></td>
</tr>
<tr>
<td><strong>If No:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INDEMNITY</td>
<td>399</td>
<td>26</td>
<td>83</td>
<td>3</td>
</tr>
<tr>
<td>(98.52%)</td>
<td>(100%)</td>
<td>(20.6%)</td>
<td>(11.54%)</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(1.48%)</td>
<td>(0%)</td>
<td>(0%)</td>
<td>(0%)</td>
<td>(0%)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Number of Telephone Contacts</td>
<td>3,938</td>
<td>16,976</td>
<td>17,152</td>
<td>26,469</td>
</tr>
<tr>
<td>Contact Rate</td>
<td>53.68%</td>
<td>58.37%</td>
<td>59.40%</td>
<td>69.37%</td>
</tr>
<tr>
<td>AVG # of Days from D/A</td>
<td>27</td>
<td>20</td>
<td>20</td>
<td>18</td>
</tr>
</tbody>
</table>

First Report of Injury Team Contact Rate
## Results

<table>
<thead>
<tr>
<th>Question</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q-5 - Have you received Adequate Treatment?</td>
<td>N/A</td>
<td>N/A</td>
<td>3.63%</td>
<td>4.41%</td>
<td>8.64%</td>
<td>6.53%</td>
<td>5.74%</td>
<td>4.99%</td>
<td>3.36%</td>
</tr>
<tr>
<td>Answer = NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q-5 Answer = NO, percent litigated</td>
<td>N/A</td>
<td>N/A</td>
<td>45.26%</td>
<td>38.55%</td>
<td>35.04%</td>
<td>34.62%</td>
<td>32.12%</td>
<td>31.70%</td>
<td>12.17%</td>
</tr>
<tr>
<td>Q-7 Have you been in Contact with Employer?</td>
<td>N/A</td>
<td>N/A</td>
<td>2.87%</td>
<td>2.56%</td>
<td>3.10%</td>
<td>2.43%</td>
<td>0.99%</td>
<td>1.00%</td>
<td>0.73%</td>
</tr>
<tr>
<td>Answer = NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q-7 Answer = NO, percent litigated</td>
<td>N/A</td>
<td>N/A</td>
<td>29.59%</td>
<td>30.45%</td>
<td>25.81%</td>
<td>26.78%</td>
<td>26.21%</td>
<td>27.17%</td>
<td>18.30%</td>
</tr>
<tr>
<td>Q-8 Have you received your first benefit check?</td>
<td>N/A</td>
<td>N/A</td>
<td>31.51%</td>
<td>20.50%</td>
<td>14.97%</td>
<td>8.77%</td>
<td>10.36%</td>
<td>11.91%</td>
<td>3.24%</td>
</tr>
<tr>
<td>Answer = NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q-8 Answer = NO, percent litigated</td>
<td>N/A</td>
<td>N/A</td>
<td>21.36%</td>
<td>22.44%</td>
<td>21.49%</td>
<td>25.37%</td>
<td>20.32%</td>
<td>20.85%</td>
<td>16.55%</td>
</tr>
</tbody>
</table>
Question 5

• In 2010 formalized process to refer IW’s who were not satisfied with medical treatment to an Ombudsman
Medical Authorization

Prior to Q-5 Referral

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Auth (28) EDU</td>
<td>564</td>
<td>1,136</td>
<td>1,682</td>
<td>1,685</td>
</tr>
<tr>
<td>Med Aut Issues</td>
<td>228</td>
<td>1,645</td>
<td>1,279</td>
<td>895</td>
</tr>
<tr>
<td>MED Auth Issues Resolved</td>
<td>159</td>
<td>1,150</td>
<td>902</td>
<td>682</td>
</tr>
<tr>
<td>% Med Auth Issues Resolved</td>
<td>69.73%</td>
<td>69.90%</td>
<td>70.52%</td>
<td>76.20%</td>
</tr>
</tbody>
</table>

After Q-5 Referral

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Auth (28) EDU</td>
<td>5,607</td>
<td>6,298</td>
<td>5,174</td>
<td>5,392</td>
<td>4,108</td>
</tr>
<tr>
<td>Med Aut Issues</td>
<td>1,077</td>
<td>814</td>
<td>653</td>
<td>565</td>
<td>491</td>
</tr>
<tr>
<td>MED Auth Issues Resolved</td>
<td>929</td>
<td>710</td>
<td>571</td>
<td>500</td>
<td>439</td>
</tr>
<tr>
<td>% Med Auth Issues Resolved</td>
<td>86.25%</td>
<td>87.22%</td>
<td>87.44%</td>
<td>88.49%</td>
<td>89.40%</td>
</tr>
</tbody>
</table>
## All Issues

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL Issues</td>
<td>990</td>
<td>4,820</td>
<td>3,841</td>
<td>2,505</td>
<td>2,518</td>
</tr>
<tr>
<td>All Issues Resolved</td>
<td>589</td>
<td>3,163</td>
<td>2,487</td>
<td>1,798</td>
<td>1,973</td>
</tr>
<tr>
<td>% All Issues Resolved</td>
<td>59.49%</td>
<td>65.62%</td>
<td>64.74%</td>
<td>71.77%</td>
<td>78.35%</td>
</tr>
<tr>
<td></td>
<td>$104,062.46</td>
<td>$934,089.21</td>
<td>$4,823,451.02</td>
<td>$1,003,054.97</td>
<td>$1,150,280.97</td>
</tr>
</tbody>
</table>

## 2011/2012 to 2014/2015

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>ALL Issues</td>
<td>1,897</td>
<td>1,480</td>
<td>1,152</td>
<td>1,127</td>
</tr>
<tr>
<td>All Issues Resolved</td>
<td>1,605</td>
<td>1,251</td>
<td>1,015</td>
<td>962</td>
</tr>
<tr>
<td>% All Issues Resolved</td>
<td>84.60%</td>
<td>84.52%</td>
<td>88.10%</td>
<td>85.35%</td>
</tr>
<tr>
<td></td>
<td>$730,833.80</td>
<td>$550,795.58</td>
<td>$392,589.57</td>
<td>$352,496.87</td>
</tr>
</tbody>
</table>
First Report of Injury Team

- Report can be run by Carrier, TPA & FEIN or any combination
- Report can be run for any time frame (i.e. Calendar year vs. fiscal year)
- Report can be sent to you on a recurring schedule (i.e. monthly, quarterly, yearly)
To receive copies of IW Survey:

- Robert Abrego – First Report of Injury Team Manager
- 813-221-6531
- Robert.abrego@myfloridacfo.com
Bureau of Employee Assistance & Ombudsman Office Services

- (800) 342-1741
- Injured Worker Helpline Team, option 2
- Customer Service Team, option 3 or workers.compservice@fldfs.com
- First Report of Injury Team
- Ombudsman / Early Intervention Team wceao@myfloridacfo.com
Questions
Carrier Compliance and Industry Performance

Pam Macon
Bureau of Monitoring & Audit
Today’s Topics

• Overview of statutory and rule requirements
• Audit Trends
• CPS Review and Performance Statistics
• Medical Services Data
• Q & A
Bureau of Monitoring & Audit

The Bureau of Monitoring and Audit (M&A) is responsible for ensuring that the practices of insurers, claim administrators and providers meet the requirements of Chapter 440, Florida Statutes and the Florida Administrative Code.
Overview of Statutory and Rule Requirements

• Payment of Medical Bills - 440.20(2)(b), F.S.

  – Carrier must pay, disallow, or deny all medical, dental, pharmacy, and hospital bills submitted to the carrier within 45 calendar days after the carrier's receipt of the bill
Overview of Statutory and Rule Requirements

• **Filing of Medical Bills** - 69L-7.710(5)(e), F.A.C.

How many days does the carrier have to file the bill with the Division?
Overview of Statutory and Rule Requirements

• **Filing of Medical Bills - 69L-7.710(5)(e), F.A.C.**

  – ... shall be filed with the Division within 45-calendar days of when the medical bill is paid, adjusted, disallowed or denied by the insurer, service company/TPA or any entity acting on behalf of the insurer...
Overview of Statutory and Rule Requirements

- **Timeliness of the Initial Indemnity Payment 440.20, F.S.**

  - Lost Time Claims:

    - (2)(a) When disability is immediate and continuous for 8 or more calendar days, the first installment is due no later than the 14th calendar day after the employer receives notification of injury or illness
Overview of Statutory and Rule Requirements

• **Timeliness of the Initial Indemnity Payment 440.20, F.S.**
  
  – Medical Only to Lost Time Claims:

  • (2)(a) When the first 7 days after disability are nonconsecutive or delayed, the first installment is due on the 6th day after the first 8 calendar days of disability
Overview of Statutory and Rule Requirements

- **Insurer Claim Reporting:** 69L-56.301, F.A.C.
  - If disability is immediate and continuous for 8 or more calendar days, the claim administrator shall file an electronic First Report of Injury and receive a “TA” (Transaction Accepted) on or before 21 days after knowledge of injury or illness
Overview of Statutory and Rule Requirements

• Insurer Claim Reporting: 69L-56.301, F.A.C.

For delayed disability, within how many days should a “TA” be received after the claim administrator’s knowledge of the 8th day of disability?
Overview of Statutory and Rule Requirements

• **Insurer Claim Reporting:**

  69L-56.301, F.A.C.

  - If disability not immediate and continuous but result in 8 or more days of disability, the claim administrator shall file the First Report of Injury and receive a “TA” (Transaction Accepted) on or before 13 days after their knowledge of the 8th day of disability.
M&A AUDIT SECTION

Pursuant to sections 440.185, 440.20, and 440.525, Florida Statutes and the rules of the Florida Administrative Code, the Audit Section examines claims-handling practices of:

– insurers

– self-insurers

– self-insurance funds

– other claim administrators
<table>
<thead>
<tr>
<th>Category</th>
<th>FY 2013/2014 Totals</th>
<th>FY 2014/2015 Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Audits</td>
<td>52</td>
<td>56</td>
</tr>
<tr>
<td>Total Files Reviewed</td>
<td>4,598</td>
<td>5,303</td>
</tr>
<tr>
<td>Files Reviewed for Indemnity Payments</td>
<td>3,040</td>
<td>3,597</td>
</tr>
<tr>
<td>Underpaid Files</td>
<td>533</td>
<td>491</td>
</tr>
<tr>
<td>Total amount of UP + P&amp;I Identified</td>
<td>$262,612</td>
<td>$310,845</td>
</tr>
<tr>
<td>Total Pattern &amp; Practice Penalties Assessed</td>
<td>$160,000</td>
<td>$202,500</td>
</tr>
</tbody>
</table>
Untimely Indemnity Payment and FRoI Penalties by Fiscal Year

<table>
<thead>
<tr>
<th>Year Range</th>
<th>Total Amount of Penalties Issued for Untimely Indemnity Payments</th>
<th>Total Amount of Penalties Issued for Untimely First Reports of Injury or Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 10-11</td>
<td>$90,400</td>
<td>$66,600</td>
</tr>
<tr>
<td>FY 11-12</td>
<td>$87,000</td>
<td>$51,200</td>
</tr>
<tr>
<td>FY 12-13</td>
<td>$64,200</td>
<td>$27,500</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>$70,850</td>
<td>$25,800</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>$83,300</td>
<td>$60,300</td>
</tr>
</tbody>
</table>
Total Non-Willful Pattern & Practice Penalties by Fiscal Year

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Penalties</th>
<th>Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 10-11</td>
<td>$240,000</td>
<td>96</td>
</tr>
<tr>
<td>FY 11-12</td>
<td>$255,000</td>
<td>102</td>
</tr>
<tr>
<td>FY 12-13</td>
<td>$102,500</td>
<td>41</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>$160,000</td>
<td>64</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>$202,500</td>
<td>81</td>
</tr>
</tbody>
</table>
## M&A Audit Trends

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Overpayment</th>
<th>Total Underpayment + P&amp;I</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 12-13</td>
<td>$202,796</td>
<td>$163,420</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>$321,967</td>
<td>$262,612</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>$267,817</td>
<td>$310,845</td>
</tr>
</tbody>
</table>
# M&A Audit Trends - Combined Audit Findings FY10-11 Through FY14-15

<table>
<thead>
<tr>
<th>Overpayment Reasons</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Made; but was Not Due</td>
<td>1,148</td>
</tr>
<tr>
<td>Wrong Calc. of the AWW/CR</td>
<td>755</td>
</tr>
<tr>
<td>TPD Benefits Paid @ the TTD Rate</td>
<td>208</td>
</tr>
<tr>
<td>Late Receipt of Wage Info.</td>
<td>149</td>
</tr>
<tr>
<td>Wrong Calc. of PT/PTS Benefits</td>
<td>138</td>
</tr>
<tr>
<td>Late Receipt of Return To Work Info.</td>
<td>40</td>
</tr>
<tr>
<td>Late Payments of Impairment Benefits</td>
<td>22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Underpayment Reasons</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>P&amp;I Was Owed but Not Paid</td>
<td>1,057</td>
</tr>
<tr>
<td>Benefits Were Due but Not Paid</td>
<td>637</td>
</tr>
<tr>
<td>Wrong Calc. of the AWW/CR</td>
<td>497</td>
</tr>
<tr>
<td>Wrong Calc. of PT/PTS Benefits</td>
<td>114</td>
</tr>
<tr>
<td>TTD Benefits Paid @ the TPD Rate</td>
<td>54</td>
</tr>
<tr>
<td>Calc. of the # of Work Days</td>
<td>49</td>
</tr>
<tr>
<td>Late Payments of Impairment Benefits</td>
<td>28</td>
</tr>
</tbody>
</table>
Electronic Notice of Action or Change, Including Change in Claims Administration

69L-56.304 & 69L-56.3045

Florida Administrative Code
Auditing Notice of Action or Change Compliance

As of **July 1, 2015**

- Compliance percentages are documented in Audit Reports, **and** Pattern and Practice Penalties are assessed for compliance percentages below 90% per 440.525(4), Florida Statutes and Rule 69L-24.007, Florida Administrative Code.
Auditing Notice of Action or Change Compliance

• Any Notice that was due prior to January 1, 2015 and filed, receiving a TA or TA-FL, prior to July 1, 2015 will not be counted in the compliance review.

• All Notices due on or after January 1, 2015, will be counted in the compliance review.
Top Ten Actions for which Notices of Change were Reported Untimely in the Last Two Fiscal Years

- Report RTW Info
- Report MMI Info
- Report a Change From TTD to TPD
- Report Adjustment to AWW/CR
- Report Annual Increase of PTD Supplemental Benefits
- Report Suspension of Benefits
- Report a Settlement
- Report Reinstatement of Benefits
- Report a Change From TPD to TTD
- Report an Acquired Claim
Notices of Action or Change Compliance by Fiscal Year

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Timely</th>
<th>Not Sent</th>
<th>Sent Late</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 10-11</td>
<td>4,578</td>
<td>673</td>
<td>1,166</td>
<td>60.00%</td>
</tr>
<tr>
<td>FY 11-12</td>
<td>4,318</td>
<td>786</td>
<td>912</td>
<td>65.00%</td>
</tr>
<tr>
<td>FY 12-13</td>
<td>4,121</td>
<td>521</td>
<td>892</td>
<td>70.00%</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>3,735</td>
<td>982</td>
<td>904</td>
<td>75.00%</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>4,647</td>
<td>734</td>
<td>922</td>
<td>80.00%</td>
</tr>
</tbody>
</table>
Notice of Change EDI Resources are available online

http://www.myfloridacfo.com/Division/WC/EDI/Clms_EDI.htm

- Edit Matrix
- Element Table
- Events Table
- EDI Training Power Point
Centralized Performance System (CPS)

- CPS is a web based application which enables:
  - The Penalty Section to evaluate and assess insurer performance of timely payments of initial indemnity benefits and medical bills
  - The Division and its stakeholders to monitor performance and respond to penalty assessments for untimely filing and untimely payment in real-time
## CPS – First Reports Reviewed

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th># of First Reports Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 10-11</td>
<td>53,285</td>
</tr>
<tr>
<td>FY 11-12</td>
<td>53,211</td>
</tr>
<tr>
<td>FY 12-13</td>
<td>51,690</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>52,344</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>53,929</td>
</tr>
</tbody>
</table>
## CPS Performance Statistics

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Timely Initial Benefit Payments</th>
<th>Timely Filing of First Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 10-11</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>FY 11-12</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>FY 12-13</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>95%</td>
<td>93%</td>
</tr>
</tbody>
</table>
## CPS Performance Statistics

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Timely Medical Bill Payments</th>
<th>Timely Medical Bill Filing</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 10-11</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>FY 11-12</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>FY 12-13</td>
<td>98%</td>
<td>96%</td>
</tr>
<tr>
<td>FY 13-14</td>
<td>99%</td>
<td>98%</td>
</tr>
<tr>
<td>FY 14-15</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>
Medical Services Section

• Responsibilities:
  – Establishing rules and policy
  – Implementing the Three-Member Panel’s uniform schedules for Maximum Reimbursement Allowances (MRAs)
  – Resolving medical reimbursement disputes between providers and payers
  – Certifying Expert Medical Advisors
Prior to July 1, 2013, a Reimbursement Dispute had to be filed within 30 days from receipt of the carrier’s notice of disallowance or adjustment of payment.

As of July 1, 2013, a Reimbursement Dispute must be filed within 45 days from receipt of the carrier’s notice of disallowance or adjustment of payment.
Medical Services Section

• Prior to July 1, 2013, the carrier had to submit, within 10 days of receipt of the petition, all documentation to the department to substantiate its disallowance or adjustment.

• As of July 1, 2013, the carrier must submit, within 30 days of receipt of the petition, all documentation to the department to substantiate its disallowance or adjustment.
Medical Services Section

• Explanations of Bill Review (EOBRs) must contain the following elements:
  – Codes from the Billing Rule
  – Compliant descriptors
  – Insurer’s name
  – Insurer’s address
  – Division-assigned insurer ID number
  – Name of the dispute copy designee
  – Name of the dispute copy designee’s address
  – Disallowance language
Medical Services Section

• Reimbursement Dispute Forms

Top Reasons forms are deficient:

• EOBR is missing
• Form is incomplete
• Proof of service on the carrier is missing
• Medical bill is not submitted with the petition
• Documentation to support disputed amount(s) is missing
<table>
<thead>
<tr>
<th>Reason</th>
<th>FY 10-11</th>
<th>FY 11-12</th>
<th>FY 12-13</th>
<th>FY 13-14</th>
<th>FY 14-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to Cure Deficiency</td>
<td>507</td>
<td>547</td>
<td>617</td>
<td>998</td>
<td>624</td>
</tr>
<tr>
<td>Untimely Filed</td>
<td>255</td>
<td>930</td>
<td>1283</td>
<td>951</td>
<td>515</td>
</tr>
<tr>
<td>Petition Withdrawn</td>
<td>295</td>
<td>437</td>
<td>1167</td>
<td>2448</td>
<td>1466</td>
</tr>
<tr>
<td>Other Reason</td>
<td>19</td>
<td>28</td>
<td>41</td>
<td>88</td>
<td>231</td>
</tr>
<tr>
<td>Lack of Jurisdiction</td>
<td>92</td>
<td>131</td>
<td>191</td>
<td>202</td>
<td>228</td>
</tr>
<tr>
<td>Non-HCP</td>
<td>30</td>
<td>13</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Managed Care</td>
<td>9</td>
<td>137</td>
<td>80</td>
<td>274</td>
<td>2</td>
</tr>
<tr>
<td>Not-Ripe for Resolution</td>
<td>34</td>
<td>32</td>
<td>25</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>Improper Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
# Medical Services Data

<table>
<thead>
<tr>
<th>Petitions Dismissal Outcomes by Provider Type</th>
<th>FY 10-11</th>
<th>FY 11-12</th>
<th>FY 12-13</th>
<th>FY 13-14</th>
<th>FY 14-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner</td>
<td>478</td>
<td>1647</td>
<td>2605</td>
<td>4432</td>
<td>2363</td>
</tr>
<tr>
<td>ASC</td>
<td>219</td>
<td>157</td>
<td>216</td>
<td>173</td>
<td>103</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>133</td>
<td>109</td>
<td>140</td>
<td>96</td>
<td>181</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>411</td>
<td>346</td>
<td>448</td>
<td>270</td>
<td>431</td>
</tr>
</tbody>
</table>
# Medical Services Data

## Determinations Issued by Reason

<table>
<thead>
<tr>
<th>Reason</th>
<th>FY 10-11</th>
<th>FY 11-12</th>
<th>FY 12-13</th>
<th>FY 13-14</th>
<th>FY 14-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-Payment</td>
<td>2,181</td>
<td>3,095</td>
<td>3,871</td>
<td>4,699</td>
<td>5,275</td>
</tr>
<tr>
<td>Correct Payment</td>
<td>41</td>
<td>83</td>
<td>118</td>
<td>127</td>
<td>40</td>
</tr>
<tr>
<td>Over-Payment</td>
<td>28</td>
<td>75</td>
<td>96</td>
<td>97</td>
<td>44</td>
</tr>
<tr>
<td>Other Finding</td>
<td>5</td>
<td>3</td>
<td>10</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>No Additional Payment Due</td>
<td>90</td>
<td>109</td>
<td>244</td>
<td>515</td>
<td>387</td>
</tr>
</tbody>
</table>
Pam Macon, Bureau Chief  
(850) 413-1708  
• Pamela.Macon@myfloridacfo.com

Derrick Richardson,  
Audit and PT Manager  
(850) 413-1671  
• Derrick.Richardson@myfloridacfo.com
Policy in the Workers’ Compensation Medical Arena

Theresa Pugh
Program Administrator
Medical Services Section
Medical Services Update

- Rulemaking Update:

  - Effective January 1, 2015 (based on date of service)
  - Summary of changes:
    - Increased Stop-Loss Reimbursement threshold
    - Increased per diem rates
    - Updated Outpatient Base Rates
    - Established geographic modifiers
Workers’ Compensation Medical Reimbursement and Utilization Review, 69L-7 Series Rules

- Overview:
  - Substantial rewrite and reorganization of existing Rule 69L-7.710, F.A.C. (aka the Billing Rule)
  - Hearing held: June 2, 2015
  - Pending Notice of Change
Medical Services Update
Current Rulemaking Development

- Workers’ Compensation Medical Reimbursement and Utilization Review, 69L-7 Series Rules
  - Rule 69L-7.710, F.A.C. has been reorganized under Rule Chapter 69L-7, F.A.C.
    - Five separate rules
      - **69L-7.710**: Definitions
      - **69L-7.720**: Forms Incorporated by Reference
      - **69L-7.730**: Health Care Medical Billing and Reporting Responsibilities
      - **69L-7.740**: Insurer Authorization and Medical Bill Review Responsibilities
      - **69L-7.750**: Insurer Electronic Medical Report Filing to the Division
Workers’ Compensation Medical Reimbursement and Utilization Review, 69L-7 Series Rules

- Summary of changes:
  - Allows for the use of revised national billing forms
  - Establishes the use of ICD-10 Coding
  - Contains billing instructions for dispensing repackaged medication
  - Updates EOBR codes, to include adding new codes
  - Incorporates Revision F
  - Updates definitions
Selected Materials Incorporated by Reference, 69L-8 Series Rules

• Overview:
  - Reorganizes incorporated materials used in conjunction with DWC medical reimbursement manuals and throughout the medical billing rule
  - Hearing held: June 2, 2015
  - Pending Notice of Change
Rule Chapter 69L-8 contains the following:

- **69L-8.071**: Materials for use with the Workers’ Compensation Health Care Provider Reimbursement Manual
- **69L-8.072**: Materials for use with the Workers’ Compensation Reimbursement Manual for Ambulatory Surgical Centers
- **69L-8.073**: Materials for use with the Workers’ Compensation Hospital Reimbursement Manual
- **69L-8.074**: Materials for use throughout 69L-7 billing rule series
Medical Services Update
Current Rulemaking Development

  - Overview:
    - Revises the manual and updates reimbursement rates for ASCs
    - Second hearing held May 27, 2015
    - Notice of Change published in the Florida Administrative Weekly 7/30/2015
Medical Services Update
Current Rulemaking Development

  - Summary of changes
    - Incorporated updated schedule of MRAs
      - Increased total MRAs from 28 to 92
      - General reimbursement
        - The MRA
        - 60% of billed charge if procedure not listed in schedule
        - An agreed upon contract price
Medical Services Update
Current Rulemaking Development

  - Summary of changes, cont.
    - Clarifies implant policy
    - Does not allow multiple surgery reduction or discounting for certain surgical services
Medical Services Update


  - Overview:
    - Adopted July 20, 2015
    - Legislative ratification required
Medical Services Update
Current Rulemaking Development

  - Summary of changes,
    - Updated MRAs to incorporate 2014 Medicare Relative Value Units (RVUs)
    - Establishes the use of ICD-10 Coding
    - Reflects the statutory change to 45 days for filing dispute petitions
    - Reference statute change regarding repackaged medications dispensed by dispensing practitioners
Medical Services Update
Current Rulemaking Development

- Expert Medical Advisors, Rule 69L-30, F.A.C.
  - Hearing held: April 14, 2015
  - Pending Notice of Change
  - Summary of changes:
    - Introduces the on-line certification and educational tutorial
    - Simplifies the qualifications for becoming a certified Expert Medical Advisor
    - Increases the reimbursement fees for EMA services
    - Establishes reimbursement fees for ancillary EMA services
Utilization and Reimbursement Dispute Rule, Rule 69L-31, F.A.C.

- Workshop- date to be announced
- Summary of changes:
  - Relaxes requirements for notices of disallowance or adjustment of payment require to file a petition
  - Eliminates Notice of Deficiencies
  - Reflects the statutory change to 45 days for filing reimbursement dispute petitions
  - Clarifies contract review in determination process
Medical Services Update

- Carrier Report of Health Care Provider (HCP) Violations Rule Chapter 69L-34, F.A.C.
  - General Violation types:
    - Improper Billing of Services
    - Improper Reporting of Services
    - Improper Form Completion
    - Standard of Care Violation, including overutilization
  - Referral Submission Types
    - Manual- Form DFS-F5-DWC-2000 Health Care Provider Referral
    - Health Care Provider Violation Website:
Medical Services Update

- Health Care Provider Violation Website: https://apps8.fldfs.com/hcprov/default.aspx
HEALTH CARE PROVIDER VIOLATION WEBSITE

Report of Violation Information

HEALTH CARE PROVIDER / RESPONDENT:
Please enter as much information as you can. Required fields are noted by an asterisk (*).

Provider Type
Provider's Florida License #

Note: Include alpha prefix in license above - ex: ME12345
Note: If you do not know the provider's license number, you can look it up on the Dept. of Health's website here

Provider's First Name
Practice Name
M.I.
Last Name
M.I. (doing business as)
Address
Address Line 2
City, State
Zip
M.N. or NNN-NNN-NNN
Phone Number

INJURED WORKER:
Injured Worker's First Name
Injured Worker's M.I.
Last Name
Injured Worker's SSN (see note below)
Date of Accident (MM/DD/YYYY)

Note: The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency training purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

Date(s) of Service for Violation
(up to 6 Dates of Service)
Medical Services Update

VIOLATION:
Violation Category
Violation Type

COMPLAINANT:
Email Address * Auto-populate fields below from my last submission
First Name * Last
Complainant is a
Company Name
Address
Address Line 2
City, State * Zip (NNNN or NNNNN-NNNN)
Complainant Phone Number * Ext.

DOCUMENTS UPLOADED FOR THIS REPORT OF VIOLATION:

UPLOAD A NEW DOCUMENT:
Document Type
Description (only required if you select ‘Other’ Type above)
Upload File Browse...
Upload Document

Note: You must upload at least 1 document above before you can Submit the Report.

Contact Information for questions or support issues: Email workers.commedservice@myfloridafo.com or call (850)413-1613.
Carrier Reports of HCP Violation Performance
Rule 69L-34, F.A.C.

HCP Violation Breakdown: Caseload by Referral Violation Type FY 14-15

- Improper Reporting of Services: 6 cases
- Improper Billing of Services: 5 cases
- Standard of Care/Overutilization: 17 cases
Carrier Reports of Provider Violations
Rule 69L-34, F.A.C.

HCP Violation Breakdown: Referral by Submitter Type
FY 14-15

- DWC Associate: 25
- Attorney: 1
- Carrier: 2

Legend:
- DWC Associate
- Attorney
- Carrier
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>FY 10-11</th>
<th>FY 11-12</th>
<th>FY 12-13</th>
<th>FY 13-14</th>
<th>FY 14-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner</td>
<td>1305</td>
<td>12,460</td>
<td>7805</td>
<td>8412</td>
<td>7061</td>
</tr>
<tr>
<td>ASC</td>
<td>655</td>
<td>687</td>
<td>737</td>
<td>665</td>
<td>331</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>436</td>
<td>332</td>
<td>350</td>
<td>266</td>
<td>478</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>1378</td>
<td>1273</td>
<td>1303</td>
<td>1069</td>
<td>1522</td>
</tr>
<tr>
<td>Total</td>
<td>3,774</td>
<td>14,752</td>
<td>10,195</td>
<td>10,412</td>
<td>9,660</td>
</tr>
</tbody>
</table>
Expert Medical Advisors

- Only 136 Expert Medical Advisors
- We need EMAs in the following specialties
  - Internal Medicine
  - Neurology and Psychiatry
  - Pain Management
  - Anesthesiology
- Eligible for use by DWC or JCC to resolve appropriateness of medical care and treatment issues
- Florida DWC EMA Website:
Medical Services Section
Bureau of Monitoring and Audit
Contact Information
(850) 413-1613

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Questions
Medical EDI Update

Michelle Carter
Administrator
Bureau of Data Quality and Collection
Discussion Topics

- Top 5 Rejected Fields
- Revision F Changes
- Revision F Phase-In
Top 5 Rejected Fields - All Submitters (Year-to-Date)

1. Explanation of Bill Review Code 1 - 27.1%
2. Provider's Florida License Number - 13.2%
3. Insurer Code Number - 10.7%
4. Service Co./TPA Location Zip - 7.5%
5. Service Co./TPA FEIN - 7.5%

All other fields combined - 34.1%
Revision F Changes
(69L-7.710)
High Level Overview of Changes to the Florida MEIG (Revision F)

- Data Element (DN) names were changed to be more consistent with national standard names.

- To minimize programming impacts, new Data Elements were added to the end of record layouts (prior to filler).

- The Florida MEIG has been reformatted and is bookmarked for ease of use.
Record Layout Changes (All Form Types)
Record Layouts Changes (All Form Types)

- Changes to national forms have been accommodated.
- The Insurer Location Zip Code will no longer be captured. This field has been changed to space filler.
- New Explanation of Bill Review (EOBR) Codes have been added.
The following Data Elements are now required:

- Claim Administrator Code Number
- Claim Administrator FEIN
- Claim Administrator Physical Postal Code
When the insurer is not using a service company/third party administrator, the insurer’s information must be listed in the Claim Administrator fields (i.e. Claim Administrator Code Number, Claim Administrator FEIN and Claim Administrator Physical Postal Code).
Form Changes
(DWC-9, DWC-10, DWC-11 & DWC-90)
Changes to the DWC-9

New fields added to the end of the Medical Bill Header portion of the record:

- ICD Type Indicator
- ICD Diagnosis Code E
- ICD Diagnosis Code F
- ICD Diagnosis Code G
- ICD Diagnosis Code H
- ICD Diagnosis Code I
- ICD Diagnosis Code J
- ICD Diagnosis Code K
- ICD Diagnosis Code L
- Resubmission Code
Changes to the DWC-9

New field added to the end of the Medical Bill Detail portion of the record:

- Additional NDC Number field for Repackaged scenarios (NDC Number - Secondary)

Changes to existing fields:

- Dashes are not to be sent when reporting NDC numbers
- The Diagnosis Pointer field is now alpha numeric (A/N)
Changes to the DWC-9

Changes to Record Lengths:

- Medical Bill **Header** Record Length increased to 700

- Medical Bill **Detail** Record Length increased to 500
Changes to the DWC-10

New field has been added to the end of the Medical Bill Detail portion of the record:

- Additional NDC Number Field for Repackaged scenarios (NDC Number - Secondary)

Changes to Existing Fields:

- Dashes are not to be sent when reporting NDC numbers
Changes to Record Lengths

- Medical Bill **Header** Record Length increased to 500
- Medical Bill **Detail** Record Length increased to 500
Changes to the DWC-11

New fields added to the end of the Medical Bill Header portion of the record:

- ICD Type Indicator
- ICD Diagnosis Code A
- ICD Diagnosis Code B
- ICD Diagnosis Code C
- ICD Diagnosis Code D

Changes to Record Lengths:

- Medical Bill Header Record Length increased to 500
DWC-90
Changes to the DWC-90

New fields added to the end of the Medical Bill Header portion of the record:

- ICD Type Indicator

Changes to Record Lengths:

- Transmission Header reduced to 300
- Medical Bill Header Record Length increased to 700
Changes to the Medical Bill Acknowledgement Report

The report name has changed from Medical Bill Processing Report to Medical Bill Acknowledgment (ACK) Report.

New fields added:

- Element Validation Error Code (represents type of error)
- Element Error Number (cross-walked to IAIABC error number)
Changes to the Medical Bill Acknowledgement Report

Changes to Record Lengths:

- Processing Response Record Length increased to 500
- Validation Error Record Length increased to 500
Revision F Phase-In Schedule
All phase-in schedule dates are based on the effective date of the Workers’ Compensation Medical Reimbursement and Utilization Rule.
Revision F Phase-in Schedule

Group 1 (Submitter ID 001 - 199)

Testing begins 150 days after the effective date of rule and must be complete within 195 days of the effective date of the rule.
Revision F Phase-in Schedule

Group 2 (Submitter ID 200 - 899)

Testing begins 195 days after the effective date of rule and must be complete within 240 days of the effective date of the rule.
Revision F Phase-in Schedule

Group 3 (Submitter ID 900 and above)

Testing begins 240 days after the effective date of rule and must be complete within 285 days of the effective date of the rule.
Please direct any questions related to Medical EDI submissions to:

MedicalDataManagementTeam@myfloridacfo.com
Slides will be made available on the Division’s website

http://www.myfloridacfo.com/Division/wc/

Thank You!