DEPARTMENT OF FINANCIAL SERVICES

# Division of Workers' Compensation

Wednesday, August 23, 2023

CFO JIMMY PATRONIS

# Regulatory and Legislative Update

**Brittany O'Neil**

Assistant Director

Brittany.oneil@myfloridacfo.com

850-413-1927

# 2023 Legislative Session

- Discussions and other bills
  - PTSD
    - 911 public safety telecommunicators
    - Crime scene investigators
    - Required counselor and extra leave

# 2023 Legislative Session

- HCP and witness fees
  - Medicare 200%
  - ~~$200~~ $300
- Additional fee schedules
  - First responder/mental
- Check-cashing database
  - 200% of total policy payroll

# HB 487

EMA

FSIGA

HCP (next slide)

DOE

Treatment Guidelines

# Health Care Provider Reimbursement
## HB 487

- 110% and 140% Medicare
- Ratification
- 2009
- 2016 & 2017
- 69L-7.020, F.A.C.

CURRENT SITUATION

# Health Care Provider Reimbursement
## HB 487

- Not subject to 3MP
- JULY 1 – annually publish updated Medicare values
- JANUARY 1 – effective
- First iteration July 1, 2024
- First effective date January 1, 2025
- Separate fee schedule and policy

NEW!

# Regulatory Activities

- 2020 edition of the Health Care Provider Reimbursement Manual –
  - *7/1/2023*
- 2020 edition of the Hospital Reimbursement Manual
  - Outpatient reimbursement based upon 60% or 75% of usual and customary charges; updated methodology resulting in MRAs for every outpatient procedure
  - Inpatient per diem schedule is strict per diem
  - *5/25/2023*
- 2020 edition of the Ambulatory Surgical Center
  - Increase in MRAs
  - *7/1/2023*

# Regulatory Activities

- Billing and Reporting Rules
  - 69L-7.730
  - 69L-7.740
  - Effective 7/1/2023
- BOC Rulemaking
  - 69L-6 Chapter (8) effective 7/18/2023
- PTSD rule
  - 69L-3.009 effective 3/8/2023
- Rule Chapter 3
- Rule Chapter 56
- Rule 22 effective 9/6/2023

# What's on My Radar for 2023

- Balance between educating and holding parties accountable
- Escalation of audit findings and penalties
- Medical authorization procedures
- Future audit components
- Communicating with injured workers and the Division
- COMMUNICATION Competition!

# Questions?

Thank you!

DEPARTMENT OF FINANCIAL SERVICES

# Factors That Affect Workers' Compensation Claims

Charlene Miller
Bureau Chief of Monitoring & Audit
Division of Workers' Compensation
Tallahassee, Florida

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# Bureau of Monitoring & Audit

## Monitoring & Audit

- Ensuring the timely and accurate payment of benefits to injured workers
- Timely and accurate filing and payment of medical bills
- Timely and accurate filing of required claims forms and other electronic data
- Responsible for ensuring that the practices of insurers and claims handling entities meet the requirements of Chapter 440 F.S. and the Florida Administrative Code
- Efficiently and effectively collecting and storing data to provide accurate, meaningful, timely, and readily accessible information to all stakeholders
- Facilitates data distribution to other Division bureaus
- Manages high volumes of data from claims-handling entities and vendors for Claims, Medical and Proof of Coverage data as required by Chapter 440, F.S. and the Florida Administrative Code

# Bureau of Monitoring & Audit Overview

- Audit Section
- Insurer Reporting Services Section (EDI & CPS)
- Permanent Total Disability Section (PT)
- Medical Services Section
- Employee Assistance Office (EAO)
- Division Tools/Resources

# Monitoring, Audit, and Investigation

Pursuant to Sections 440.185, 440.20, and 440.525, F.S. and 69L-24, 69L-56 and 69L-3 the Florida Administrative Code, the Audit Section examines claim-handling practices of:

- ❑ Insurers
- ❑ Self-insurers
- ❑ Self-insurance funds
- ❑ Other claim-handling entities

# M&A Audit Section

- Completed 44 on-site insurer audits
- Examined 6,187 insurer claim files
- Identified 3,398 files with underpayments which resulted in additional injured worker payments of $429,842.74 for indemnity benefits, penalties, and interest

# M&A Audit Section
# FY 2021-2023

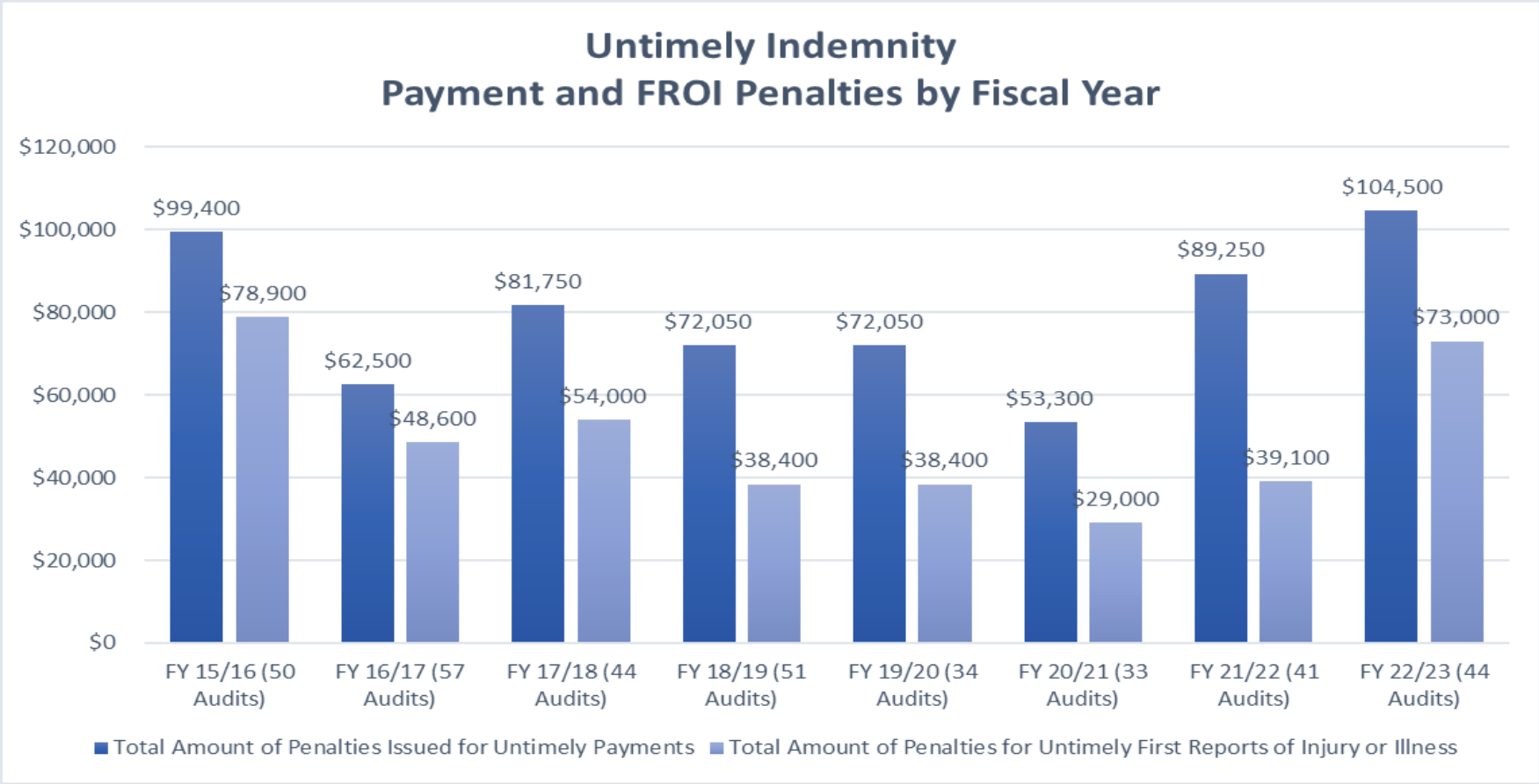
## FY 2021-2022

| Category | Totals |
|---|---|
| Number of Audits | 41 |
| Total Files Reviewed | 6,446 |
| Files Reviewed for Indemnity Payments | 3,939 |
| Underpaid Files | 537 |
| Total amount of UP + P&I Identified | $472,177.00 |
| Total Pattern & Practice Penalties Assessed | $245,000.00 |

## FY 2022-2023

| Category | Totals |
|---|---|
| Number of Audits | 44 |
| Total Files Reviewed | 6,187 |
| Files Reviewed for Indemnity Payments | 3,398 |
| Underpaid Files | 516 |
| Total amount of UP + P&I Identified | $429,842.74 |
| Total Pattern & Practice Penalties Assessed | $305,000.00 |

# M&A Audit Section Audit



## UP + P&I Payable to Injured Workers

FYE

| 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|
| $337,728 | $270,124 | $467,161 | $468,898 | $376,787 | $326,901 | $472,177 | $429,843 |

## # of Injured Workers Who Were Under Paid

FYE

| 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|---|---|
| 749 | 706 | 637 | 682 | 431 | 660 | 537 | 516 |

# Calculation of the Comp Rate

- Section 440.15, F.S. states the compensation rate for permanent total and temporary disability benefits is “66 2/3 percent of the average weekly wages”.

- When determining the compensation rate, the calculated amount should be:
  - 66 2/3% or
  - 66.67

# Calculation of the Comp Rate (continued)

Examples:

- AWW x 66 2/3 (66.67)
  $550 (AWW) x 66.67 = $366.685
  (rounded to the nearest hundredth = $366.69)

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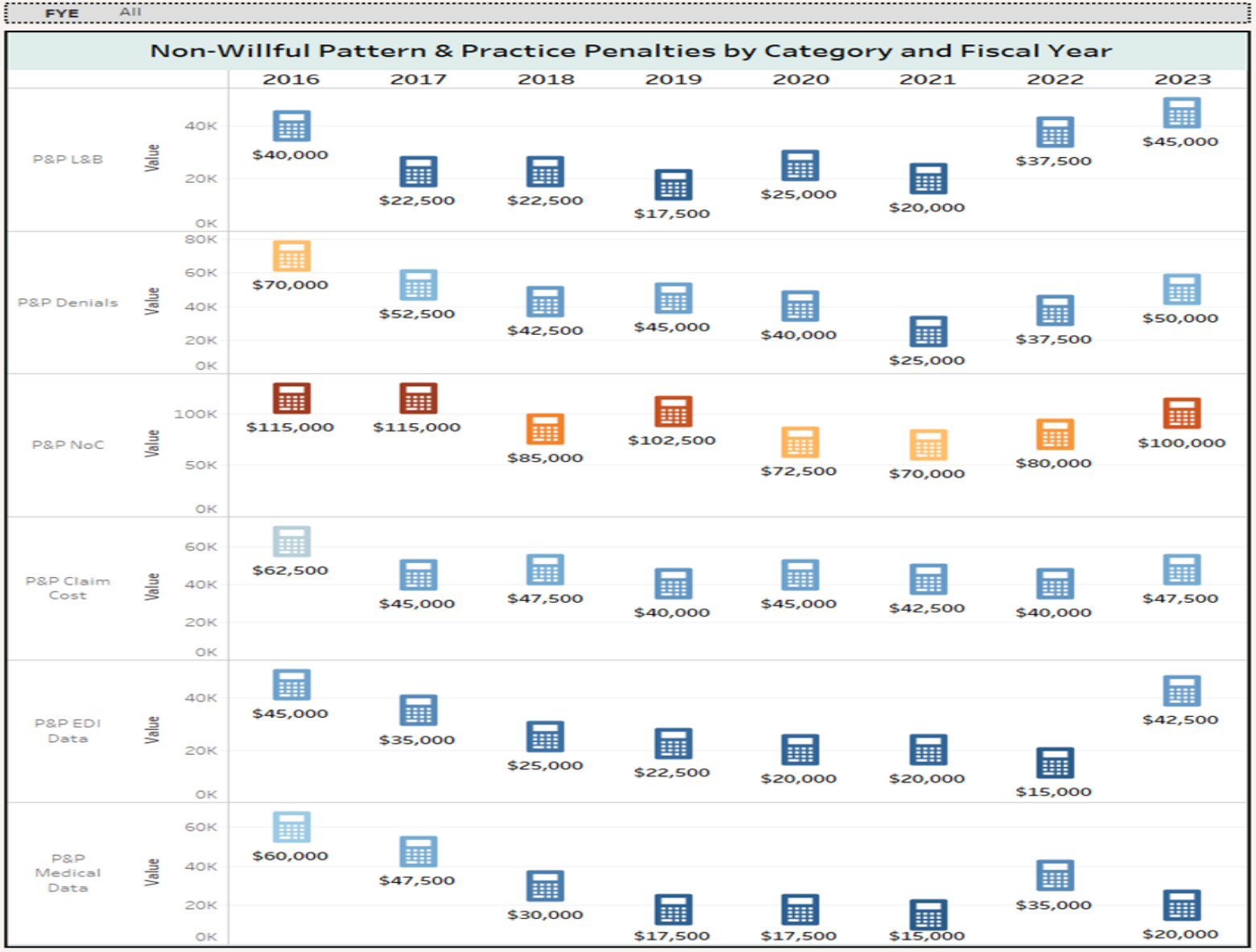


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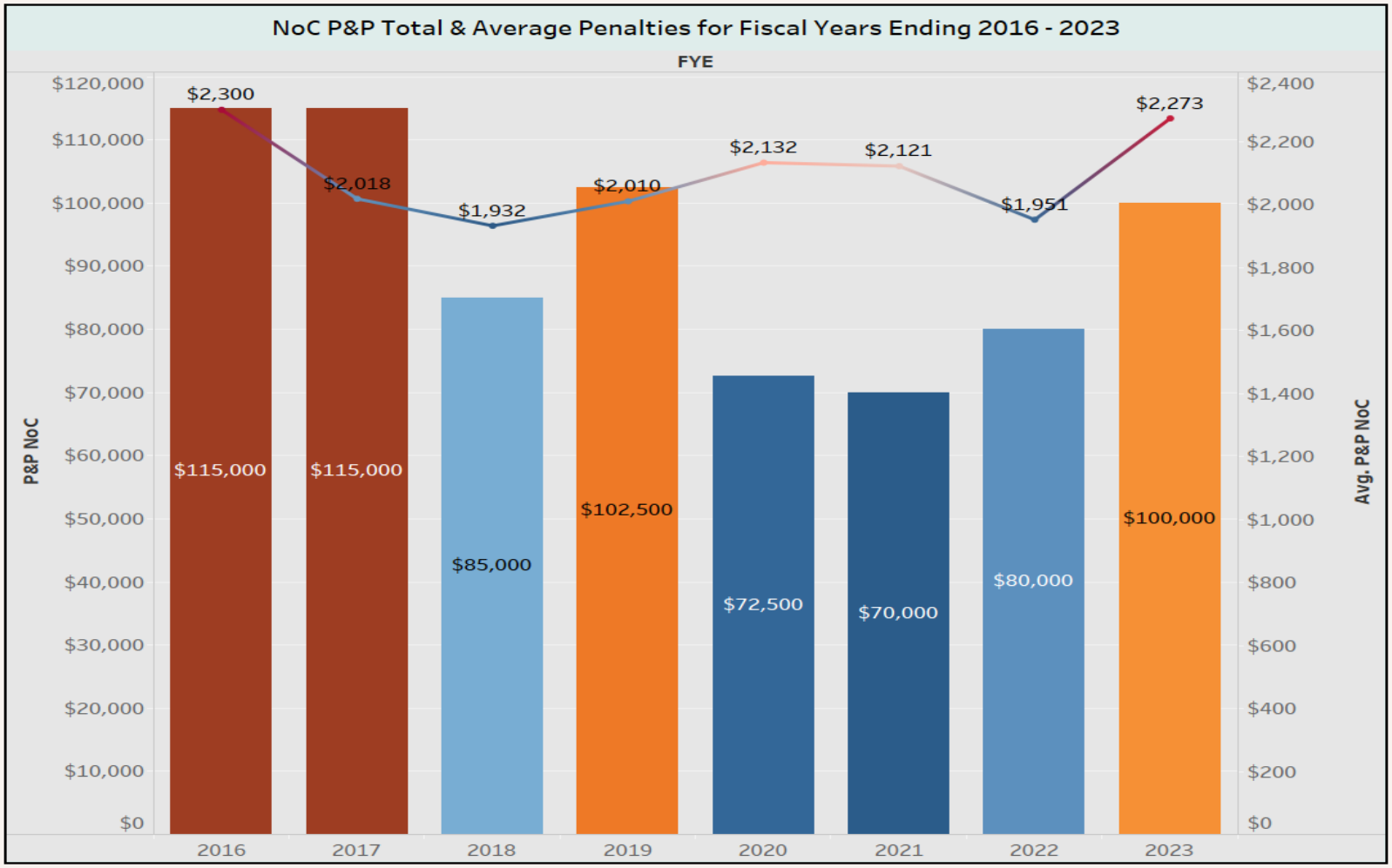
# Auditing Notice of Action or Change Compliance

- 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.


NoC P&P Total & Average Penalties for Fiscal Years Ending 2016 - 2023
FYE
P&P NoC
Avg. P&P NoC
$120,000
$110,000
$100,000
$90,000
$80,000
$70,000
$60,000
$50,000
$40,000
$30,000
$20,000
$10,000
$0
$2,400
$2,200
$2,000
$1,800
$1,600
$1,400
$1,200
$1,000
$800
$600
$400
$200
$0
$2,300
$2,018
$1,932
$2,010
$2,132
$2,121
$1,951
$2,273
$115,000
$115,000
$85,000
$102,500
$72,500
$70,000
$80,000
$100,000
2016
2017
2018
2019
2020
2021
2022
2023

FY 22/23 Notices of Action or Change Filed Late

| Reason Notice of Change was ResonNecessary | # of Late Forms |
|---|---|
| Report RTW Info | 168 |
| Report MMI Info | 154 |
| Report Suspension of Benefits | 112 |
| Report Adjustment to AWW/CR | 75 |
| Report a Change From TTD to TPD | 72 |
| Report a Settlement | 67 |
| Adjuster Error | 52 |
| Report Annual Increase of PTD Supps | 42 |
| Report an Acquired Claim | 42 |

FY 22/23 Notices of Action or Change **Not Filed**

| Reason Notice of Change was Necessary | # of Not Filed Forms |
|---|---|
| Report RTW Info | 168 |
| Report MMI Info | 107 |
| Report a Change From TTD to TPD | 75 |
| Report Suspension of Benefits | 58 |
| Adjuster Error | 43 |
| Report Adjustment to AWW/CR | 42 |
| Report Annual increase of PTD Supps | 41 |
| Report a Settlement | 36 |
| Report an Acquired Claim | 24 |
| Report the Recoupment of Paid Benefits | 12 |

FY 22/23 Notices of Action or Change **Was Necessary**

| Reason Notice of Change was Necessary | # of Untimely Forms (Late + Unfiled) |
|---|---|
| Report RTW Info | 336 |
| Report MMI Info | 261 |
| Report Suspension of Benefits | 170 |
| Report a Change From TTD to TPD | 147 |
| Report Adjustment of AWW/CR | 117 |
| Report a Settlement | 103 |
| Adjuster Error | 95 |
| Report Annual increase of PTD Supps | 83 |
| Report an Acquired Claim | 66 |
| Report Reinstatement of Benefits. | 54 |

# EDI Form Filing Requirements for the Notice of Action or Change

# Reporting of the Notice of Action or Change

- Rule 69L-56.304, F.A.C. - 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.
- Rule 69L-3.025, F.A.C. - The claim administrator shall send Form DFS-F2-DWC-4 to the Division within 14 days of the claim administrator's knowledge of the action or change which it is reporting.

# Reporting of the Notice of Action or Change

Types of actions or changes required to be reported:

- Return to work date
- Suspension of benefits
- Date of Maximum medical improvement and Permanent impairment ratings
- AWW/CR changes
- SSN changes
- Date of Injury changes

# Reporting of the Notice of Action or Change

Types of action or changes continued:

- Correction in claim numbers
- Changes in disability types
- PT Acceptance dates, increases and offsets
- Settlements
- Subsequent dates of death
- Acquired claim administrator information

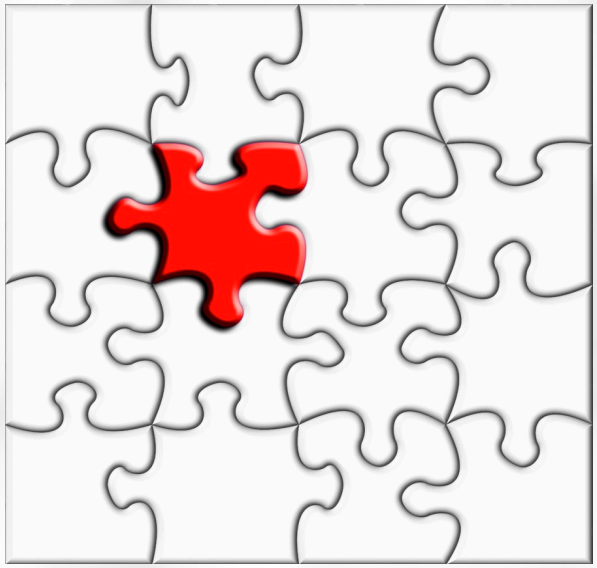
# Insurer Reporting Services Section (IRSS)

Identifies:

- Collection, quality control, analysis and reporting of claims data
- Collection, quality control, analysis and reporting of medical data
- Assessing penalties for late reporting, benefit payments, or medical payments (CPS)

# Missing SA

## (Sub-Annual)



# Missing SA (Sub-Annual)

- An MTC ‘SA’ (Sub-Annual) is the transaction used to report the accumulated cost records for an injury and is due every 6 months from the date of injury while the claim is open.
- An MTC ‘FN’ (Final) is the transaction used to report  the final accumulated cost records for an injury, once a claim is closed.

DEPARTMENT OF FINANCIAL SERVICES

# Report Card

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# Missing SA
# (Sub-Annual)

An MTC SA is considered late
if it was not accepted on or before
30 days after the SA's due date.

# Report Card
# (SA Rankings)

## Missing SA Rankings will appear on the Report Card

**Missing and Late SA counts and rankings, AS OF 05/21/2013**

| | |
|---|---|
| **Total Missing SAs:** | **17** |
| **Missing SA Rank:** | 107 out of 169 Trading Partners |
| **Total Late SAs:** | **9** |
| **Late SA Rank:** | 116 out of 169 Trading Partners |

# Report Card

# Report Card (Reoccurring Errors)

Listed below is an example of how reoccurring errors will appear on the Report Card:

Error count

**Top 10 Reoccurring Errors per MTC**

| Error | MTC | # of Times Occurred |
|---|---|---|
| 0001/042 - BOTH FROI & SROI MUST PASS EDITS TO ACCEPT FILING | 00/IP | 10028 |
| 0090/111 - COMBINED WKS/DYS > DOI THRU LATEST BEN THRU DATE | SA | 9360 |
| 0288/044 - NBR OF BENEFITS SHOULD NOT BE > WHAT IS ON FILE | SA | 8656 |
| 0086/059 - BENEFIT TYPE AMOUNT PAID < PREVIOUSLY REPORTED | CA | 8281 |
| 0187/064 - CLM ADM FEIN MUST BE VALID FOR INSURER | 02 FROI | 7733 |
| 0200/039 - CLM ADM ALT ZIP MUST = CA ALT ZIP ON EDI FORM 2A | 02 FROI | 6580 |
| 0187/118 - CLM ADM FEIN MUST BE VALID PER DWC FORM EDI2 OR 2A | 02 FROI | 6478 |
| 0174/045 - GROSS WKLY AMT IS > $.05 UNDER CALC GROSS WKLY AMT | CA | 6439 |
| 0086/111 - BT AMT PD < $5 OF FL CALC NET X BT WKS/DYS | S1 | 5722 |
| 0174/044 - GROSS WKLY AMT IS > $.05 OVER CALC GROSS WKLY AMT | CA | 5562 |

# Rejected But Not Resubmitted Report Card

**Rejected but not resubmitted as of 06/30/2023**

**651 cases exist for which the DWC-1 has been rejected and not successfully resubmitted.**

**8,190 cases exist for which one or more DWC-13 has been rejected and not successfully resubmitted.**

**(See the Claims EDI Warehouse for a complete listing of outstanding EDI filings)**

# EDI Triage Assistance

# 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

| Fiscal Year | # of First Reports Reviewed |
|---|---|
| **FY 18-19** | 55,991 |
| **FY 19-20** | 57,335 |
| **FY 20-21** | 77,341 |
| **FY 21-22** | 64,540 |
| **FY 22-23** | 40,295 |

# CPS

| Fiscal Year | Timely Initial Benefit Payments | Timely Filing of First Reports |
|---|---|---|
| FY 18-19 | 94% | 94% |
| FY 19-20 | 94% | 94% |
| FY 20-21 | 92% | 86% |
| FY 21-22 | 93% | 92% |
| FY 22-23 | 94% | 94% |

# CPS

| Fiscal Year | Timely Medical Bill Payments | Timely Medical Bill Filing |
|---|---|---|
| FY 18-19 | 98% | 98% |
| FY 19-20 | 98% | 99% |
| FY 20-21 | 98% | 99% |
| FY 21-22 | 99% | 99% |
| FY 22-23 | 98% | 99% |

# PERMANENT TOTAL DISABILITY SECTION

Division pays permanent total supplemental benefits on accidents prior to July 1, 1984 to eligible injured workers

FY 2022 - 2023 supplemental benefits for 520 claims totaling over $8 million were calculated, approved, and processed

# 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

# MEDICAL SERVICES SECTION

- A Petition for Reimbursement Dispute must be filed within 45 days from receipt of the carrier's notice of disallowance or adjustment of payment.

- The carrier must submit, within 30 days of receipt of the petition, its response and all documentation to the department to substantiate its disallowance or adjustment.

# MEDICAL SERVICES SECTION

- During Fiscal Year 2022-2023, the Medical Services Section:
  - Received 9,762 Petitions
  - Determinations 2,215
  - Dismissed 3,895

# Top 5 EOBR Codes

| EOBR CODES | OCCURRENCE |
|---|---|
| **85** - Payment adjusted: no modification to the information provided on the medical bill. Payment made pursuant to a letter of agreement between the health care provider and the carrier for a specific date of service or procedure. | 28,624 |
| **30** -Payment disallowed: lack of authorization: no authorization given for service rendered or notice provided for emergency treatment | 14,894 |
| **80** - Payment adjusted: billing error: correction of procedure, modifier, supply code, units, or Original Manufacturer's NDC Number (shall identify correction). | 11,973 |
| **40** -Payment disallowed: insufficient documentation: documentation does not substantiate the service billed was rendered. | 10,079 |
| **81** - Payment adjusted: billing error: payment modified pursuant to a charge audit. | 9,105 |

# EXPLANATIONS OF BILL REVIEW (EOBRs)

What is the purpose of the EOBR?

The purpose is to communicate to the provider, the carrier's decision to pay, disallow or adjust reimbursement.

The carrier is required to explain the reimbursement for each billed line item by using the EOBR codes (listed in Rule within subsection 69L-7.740(13)(b), F.A.C.) that best describe the carrier's reimbursement decision.

# EXPLANATIONS OF BILL REVIEW

Explanations of Bill Review (EOBRs) **must contain** the following elements per rule 69L-7.740, F.A.C.:

- Insurer's name;
- Insurer's mailing address;
- Division-issued insurer ID number
- EOBR Codes from the Billing Rule
- Compliant descriptors
- Name of the dispute copy designee
- Name of the dispute copy designee's mailing address
- Disallowance language

# Division Contacts:

- **Bureau Chief, Bureau of Monitoring & Audit**
  - Charlene.Miller@myfloridacfo.com
  - (850) 413-1738

- **Operations Management Consultant**
  - Derrick.Richardson@myfloridacfo.com
  - (850) 413-1671

- **Operations Management Consultant**
  - Michelle.Carter@myfloridacfo.com
  - (850) 413-1701

# Education and Information


Home / Employees / Education and Information

## Education and Information

The Bureau of Employee Assistance and Ombudsman Office is here to answer your questions about your indemnity benefits, medical treatment, the workers' compensation system and help you return to work. Our services are free, so please click below to learn more about workers' compensation insurance.

- Have you received a Notice of Action/Change Form?
- Have you been released to Return to Work?
- Injured Worker Brochure: English | Spanish
- Injured Worker Workshop (PowerPoint): English | Spanish
- Frequently Asked Questions

### Contact Us

Questions? Need Help? Call: (800) 342-1741, (850) 413-1610, or email us:

Email us

## Online Tools and Resources

### Online Services

DWC-4 Form Notice of Action or Change

Return to Work

### Documents & Forms

Employee Brochure: English | Spanish

Injured Worker Workshop (English)

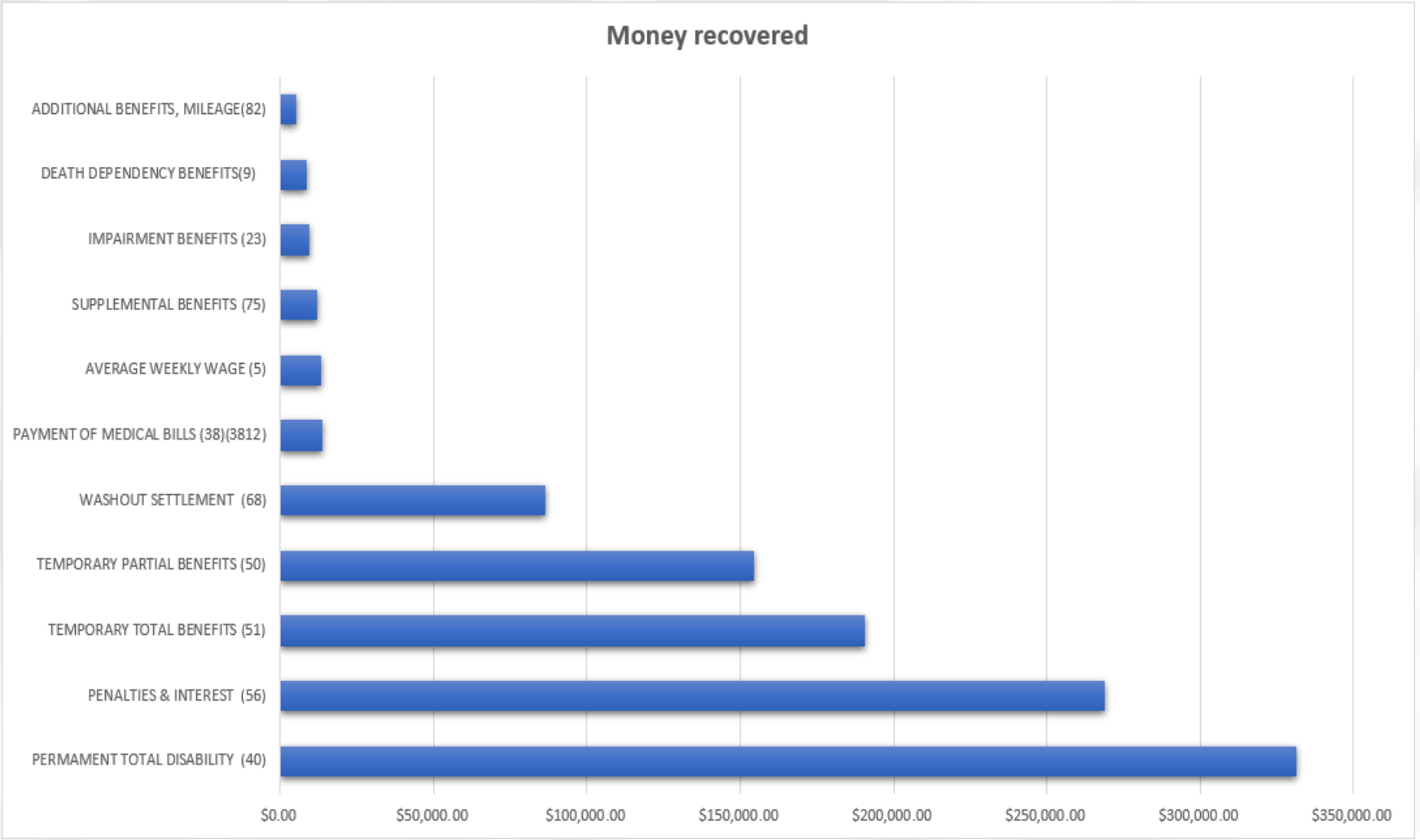
Injured Worker Workshop (Spanish)

# Our Roles & Responsibilities

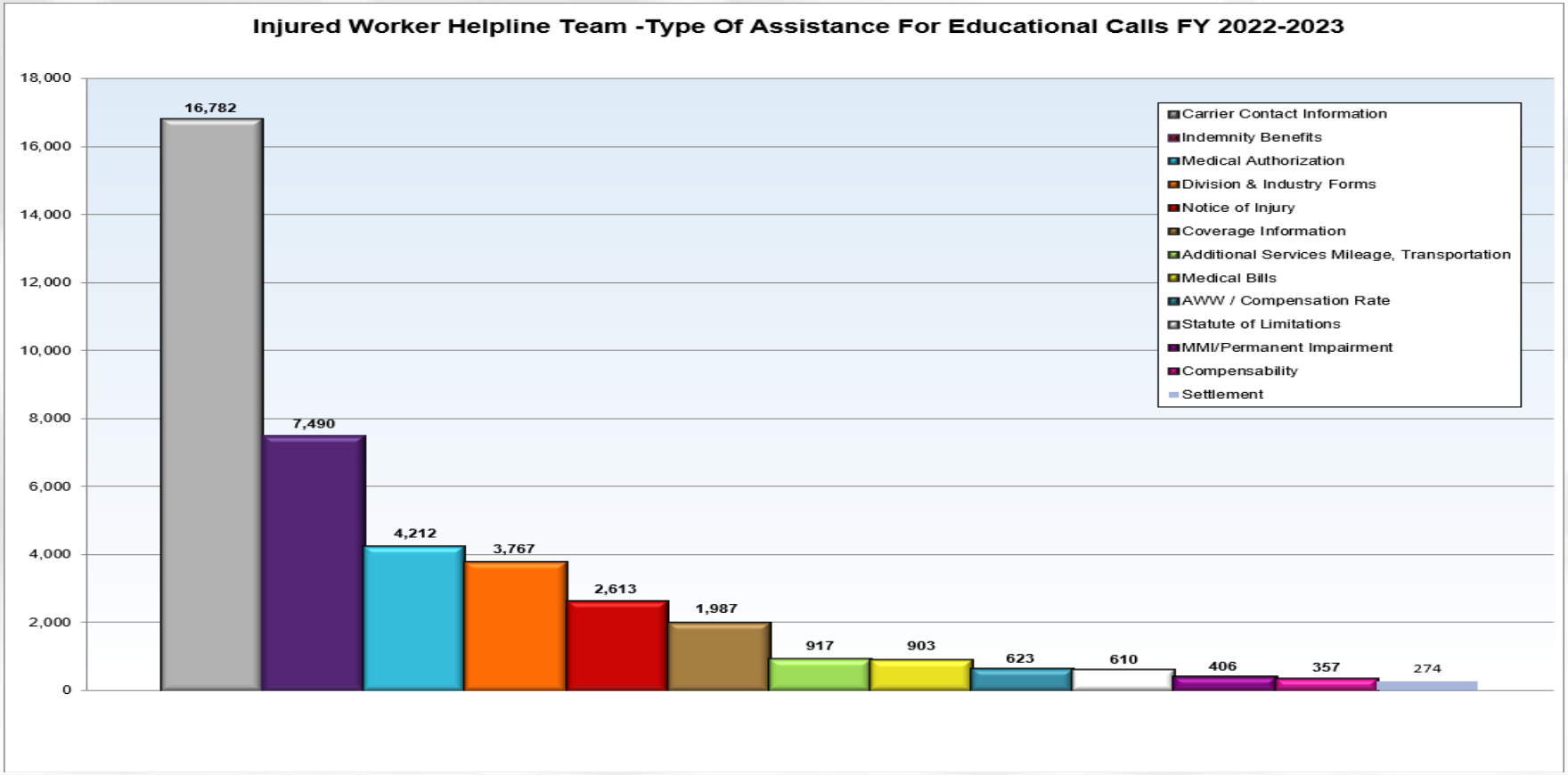
Employee Assistance & Ombudsman(EAO)

- 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.
- 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.
- Provides for collection, distribution and archival of the Division' s imaged records.
- Provides public record information.
- Responds to requests for Division data

# What was recovered ? Fiscal Year 22/23

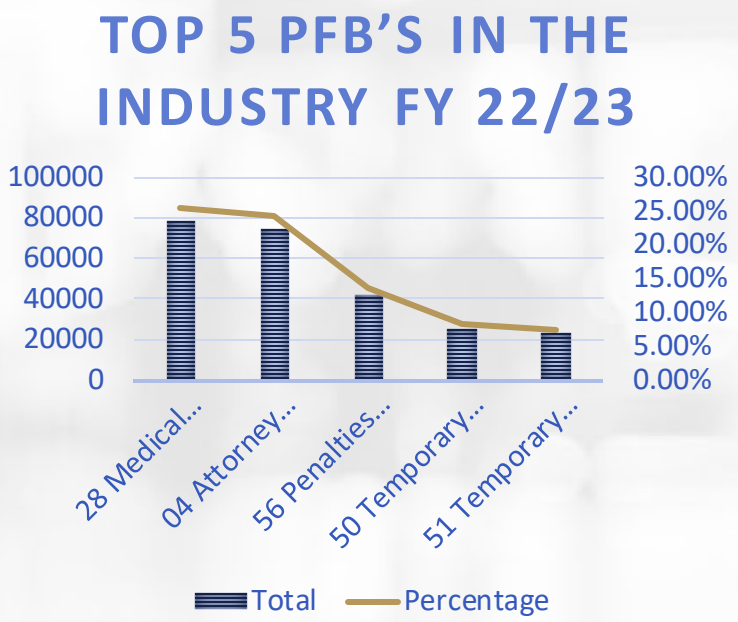


# Employee Assistance & Ombudsman(EAO)



# Top 5 PFB's in the Industry 2022-2023

| Top 5 issues filed for PFB | Total | Percentage |
|---|---|---|
| 28 Medical Authorization | 78,634 | 25.54% |
| 04 Attorney Fees and/or Costs | 74,774 | 24.29% |
| 56 Penalties and/or Interest | 41,536 | 13.49% |
| 50 Temporary Partial Disability | 25,440 | 8.26% |
| 51 Temporary Total Disability | 22,863 | 7.43% |



# Interview with an Injured Worker

1. Can you briefly describe your injury and if you have any experience dealing with WC?
2. Can you share what your WC experience has been like from the start?
3. Did you receive any contact information from your insurance carrier?
4. Were you provided any identifying information about your claims representative?
5. Have you been provided and WC materials? (The statute requires 3 days for carriers to send out WC materials for your benefit)
6. Are you receiving authorized medical care for your injury?
7. When was your initial treatment and when was your date of accident?
8. Did the initial HCP refer you for any additional treatment/services? If yes, what were they?
9. How long did it take to receive the treatment after obtaining the initial referral?
10. Please explain your experience.
11. As of today, do you think you have received adequate medical treatment for your injury. If no, what are your specific concerns.
7. Are you currently out of work due to your injury?
8. Explain your experience with the communication efforts from the claim's administrator regarding your benefits.
9. Explain your experience with the communication efforts from your employer regarding the incident.
10. Have you received your first benefit check?
11. Based on your experience how would you grade the work comp system overall?
12. Based on your experience on the grade, what improvements would you like to see?

# EAO Contacts:

**Bureau Chief, Employee Assistance & Ombudsman Office**

Lisel.Laslie@myfloridacfo.com (850) 413-1737

**Sr. Management Analyst Supervisor**
**Ombudsman & Re-employment Teams**

Mary.Cilek@myfloridacfo.com (850) 413-1638

**Operations & Management Consultant Manager**
**Injured Worker Hotline/First Report Teams**

Robert.Abrego@myfloridacfo.com (800) 342-1741 ext. 43243

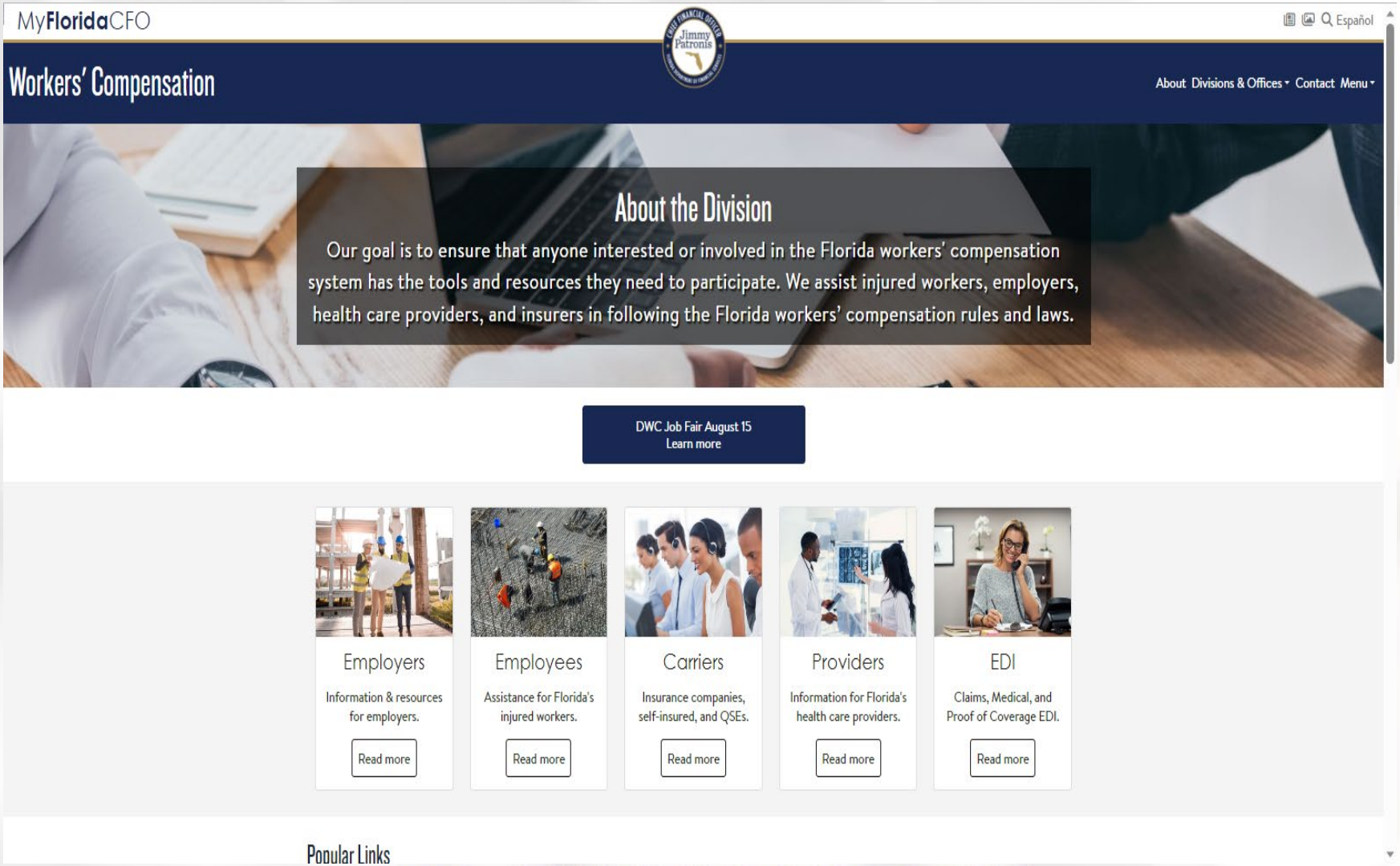
**Sr. Management Analyst Supervisor – Customer Service Team**

Leslie.Caraballo@myfloridacfo.com (850) 413-1861

**Sr. Management Analyst Supervisor – Records Management Team**

Stuart. Scott@myfloridacfo.com (850) 413-1704

# The Division's Website



# Questions

DEPARTMENT OF FINANCIAL SERVICES

# Medical Services Section Update

Theresa Pugh
Program Administrator
Medical Services Section

CFO JIMMY PATRONIS

# Medical Services Section
# Core Functions

- Expert Medical Advisor certification and Expert Medical Advisor database maintenance
- Reimbursement dispute resolution
- Investigation and determination of healthcare provider utilization patterns, billing practices, or violations of law or rules that may require penalties
- Medical services billing, filing, and reporting
- Development of Workers' Compensation Reimbursement Manuals, in collaboration with the Three-Member Panel
- Provision of educational and technical support regarding the aspects of medical services in response to inquiries

# Expert Medical Advisors, Rule 69L-30, F.A.C.

69L-30.002
Definitions

69L-30.003
Qualifications for Expert Medical Advisor Certification and Re-Certification

69L-30.004
Application Process for Expert Medical Advisor Certification

69L-30.005
Selection of Expert Medical Advisors

69L-30.006
Temporary Expert Medical Advisors

69L-30.007
Expert Medical Advisor Responsibilities

69L-30.008
Billing and Reimbursement for Expert Medical Advisor Services

69L-30.010
Expert Medical Advisor Decertification

# Expert Medical Advisors, Rule 69L-30, F.A.C.

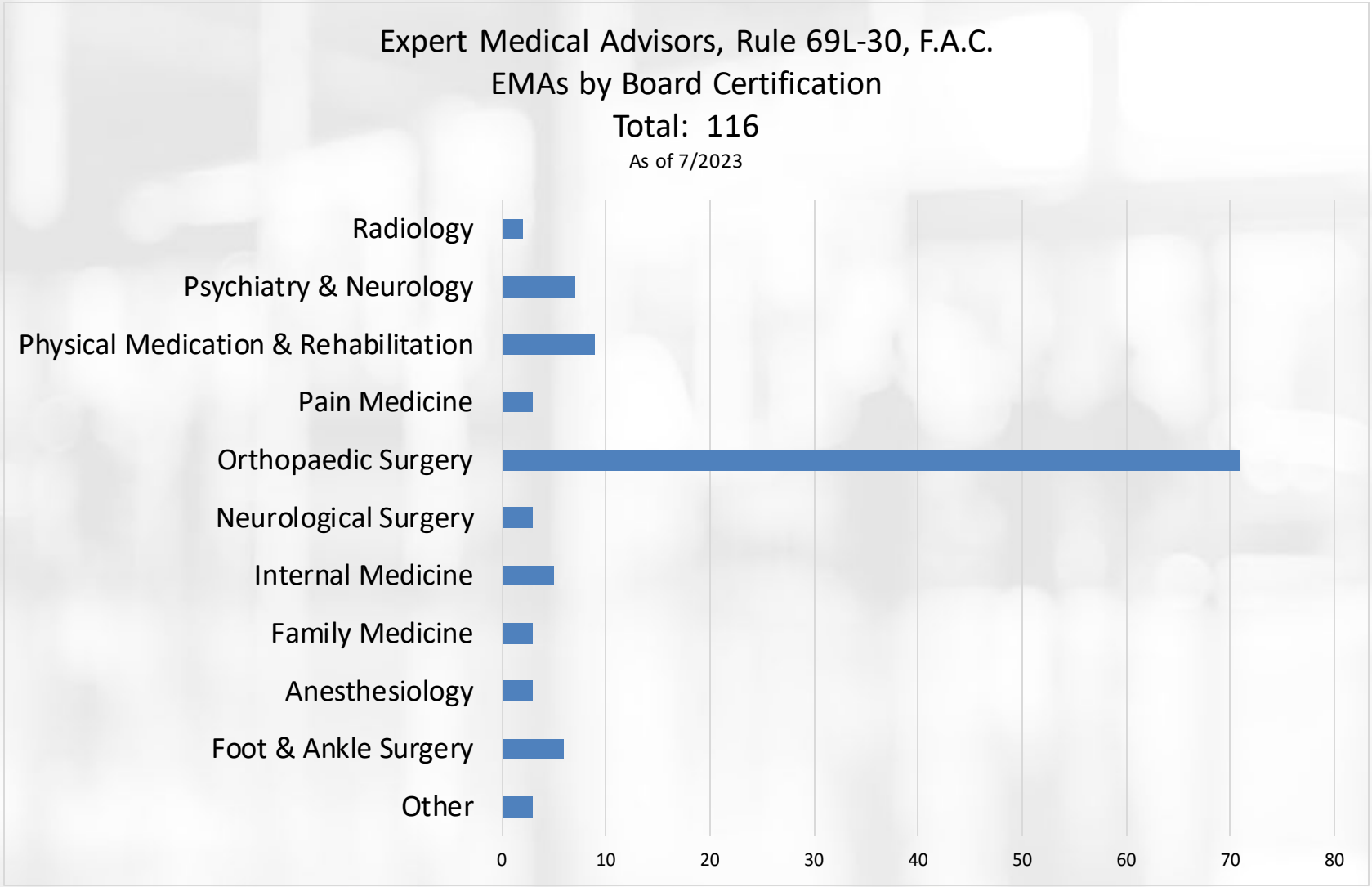
- Covers Expert Medical Advisor certification and Expert Medical Advisor database maintenance
- In effect since May of 2017
- No changes, however, pursuing additional avenues for increasing EMA enrollment

# Expert Medical Advisors, Rule 69L-30, F.A.C.

## EMA Qualifications

- Must have correctly answered 95% of the EMA Tutorial review questions
- Must hold valid licensure, issued by the Florida Department of Health, with "clear active" status
- Must demonstrate board certification or board eligibility applicable to the specialty for which the applicant seeks
- Must demonstrate experience in the assignment of permanent impairment ratings to Florida's injured employees
- Must demonstrate experience in performing Independent Medical Examinations
- Must have completed twenty hours of continuing medical education specifically related to the physician's field of specialty, within the two-year period immediately preceding the date of application

# Expert Medical Advisors, Rule 69L-30, F.A.C.



# Expert Medical Advisors, Rule 69L-30, F.A.C.

## Florida DWC EMA website

- Apply for EMA certification:
  https://msuwebportal.fldfs.com/
- Search EMA database:
  https://apps.fldfs.com/provider/

# Utilization and Reimbursement Dispute Rule, Rule 69L-31, F.A.C.

69L-31.002
Definitions

69L-31.003
Petition for Resolution of Reimbursement Dispute Form and Requirements

69L-31.004
Carrier Response to Petition for Resolution of Reimbursement Dispute Form and Requirements

69L-31.005
Written Determinations

69L-31.007
Service of Petition on Carrier and All Affected Parties

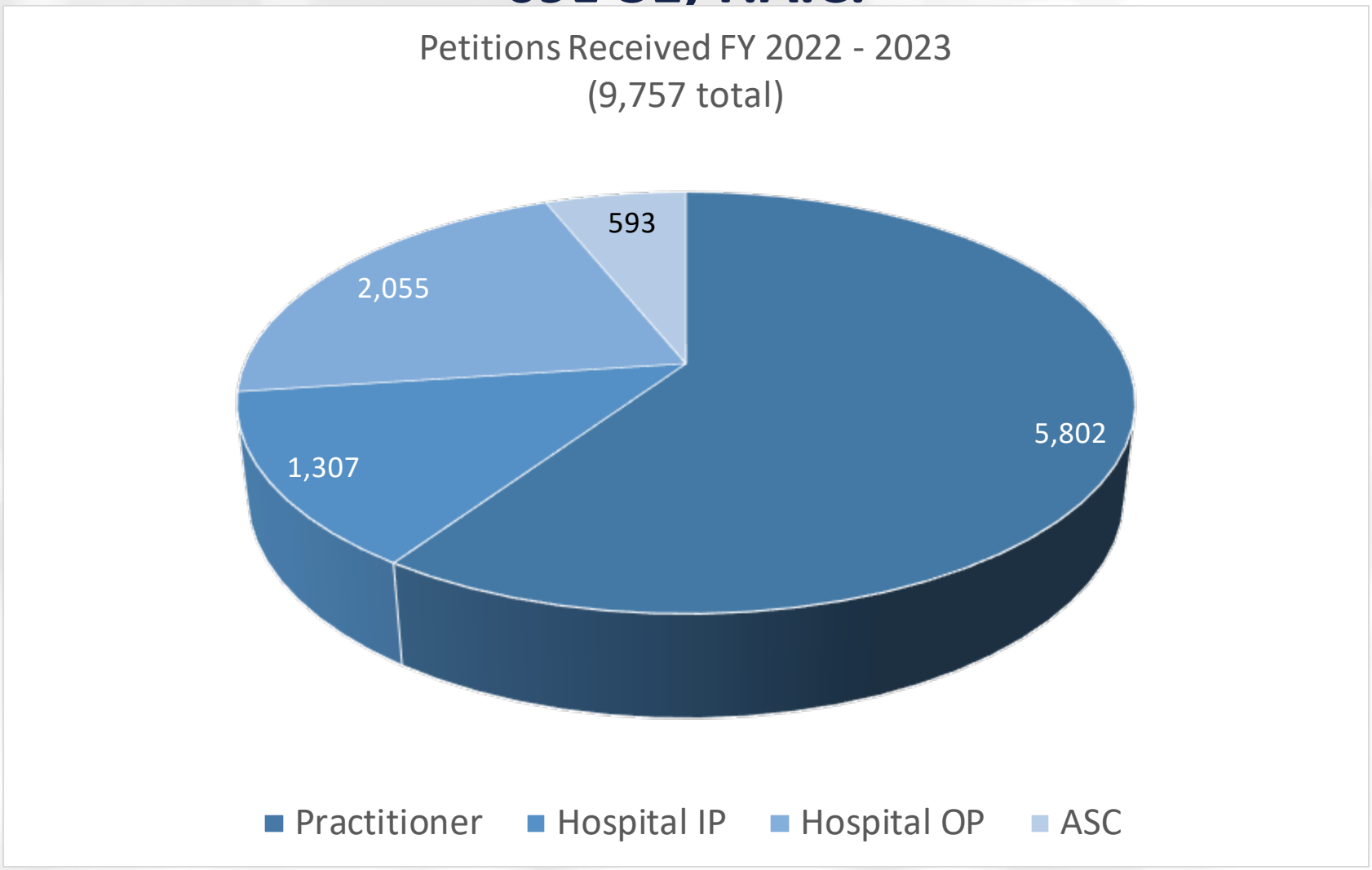
69L-31.008
Computation of Time

69L-31.013
Petition Withdrawal

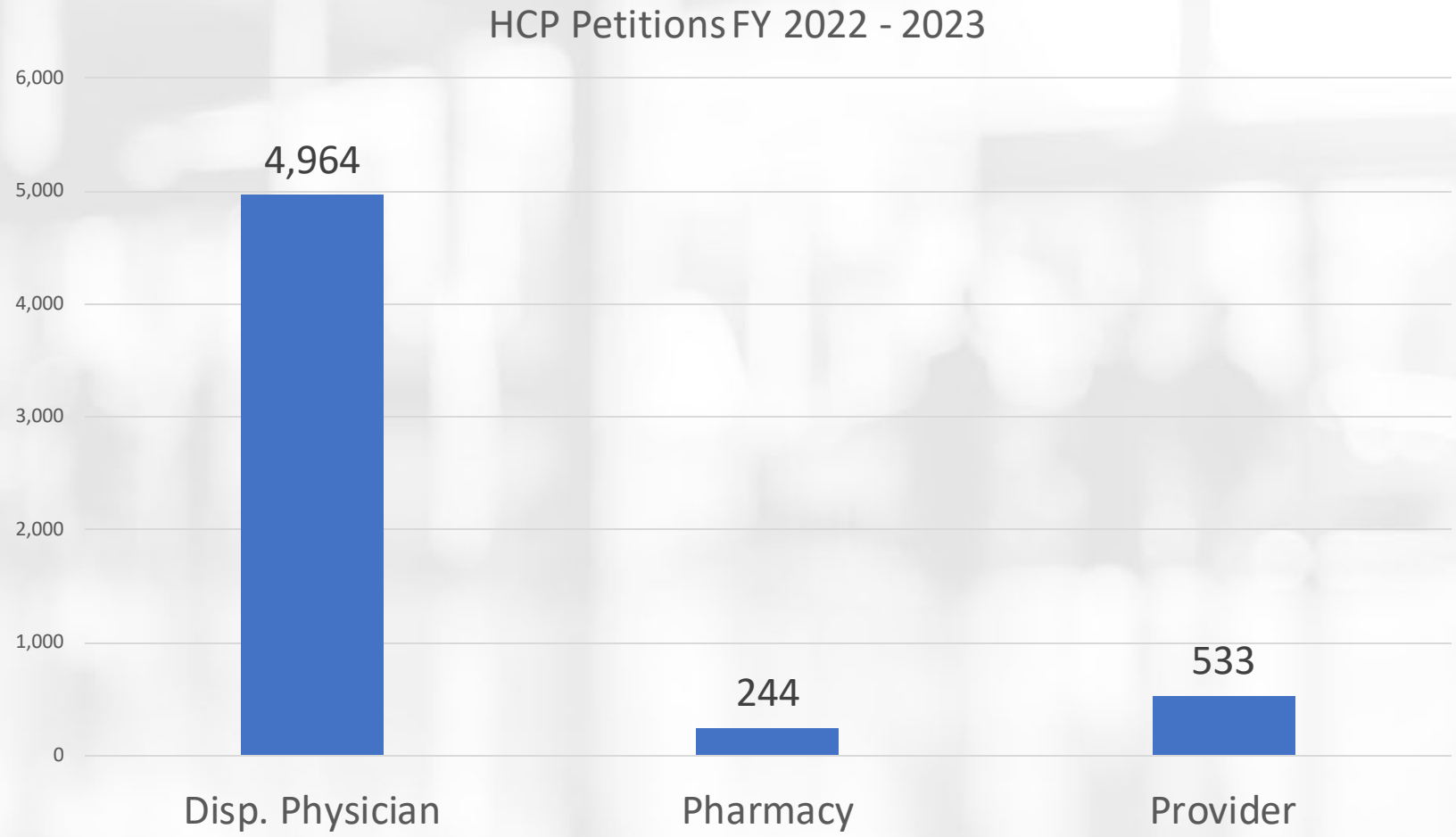
# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.

- Reimbursement dispute resolution
- Effective August 2, 2021
- No change

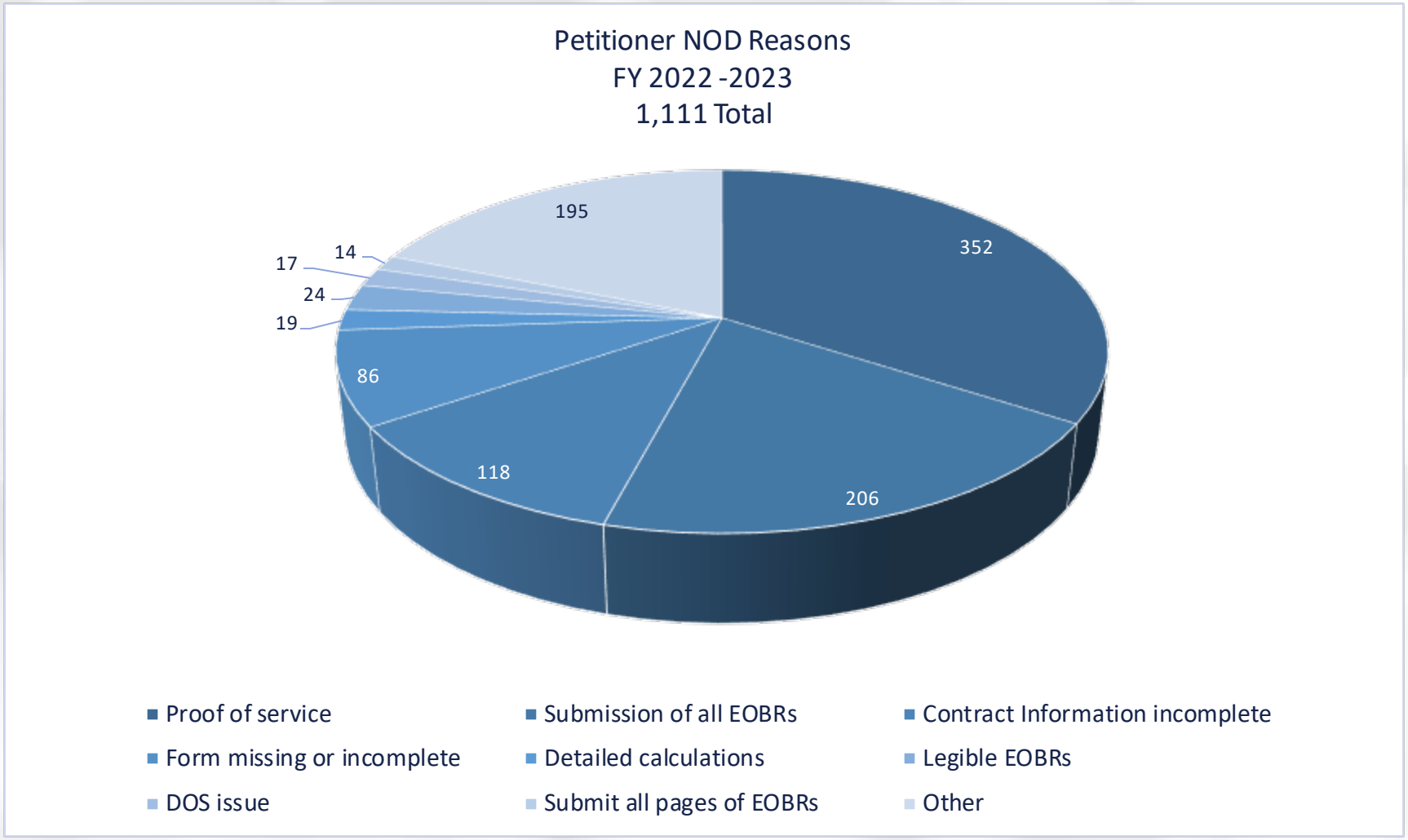
# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.



# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.



# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.



# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.

- Incoming Petitions
  - Complete entire form
  - Do not use one petition form to cover multiple petitions
  - Provide proof of service
  - Use the date on the EOBR, not the check date
  - The contract must have all relevant provisions and be in effect
  - Question 1 should contain a date, not the carrier's name

**1. Date of receipt of the Notice of Disallowance or Adjustment from the Carrier:** _____

**Select the method used to establish the date of receipt of the Notice of Disallowance or Adjustment:**

☐ **Date Stamp** (a date-stamped Notice of Disallowance or Adjustment will be accepted as proof of date of receipt by date stamp).

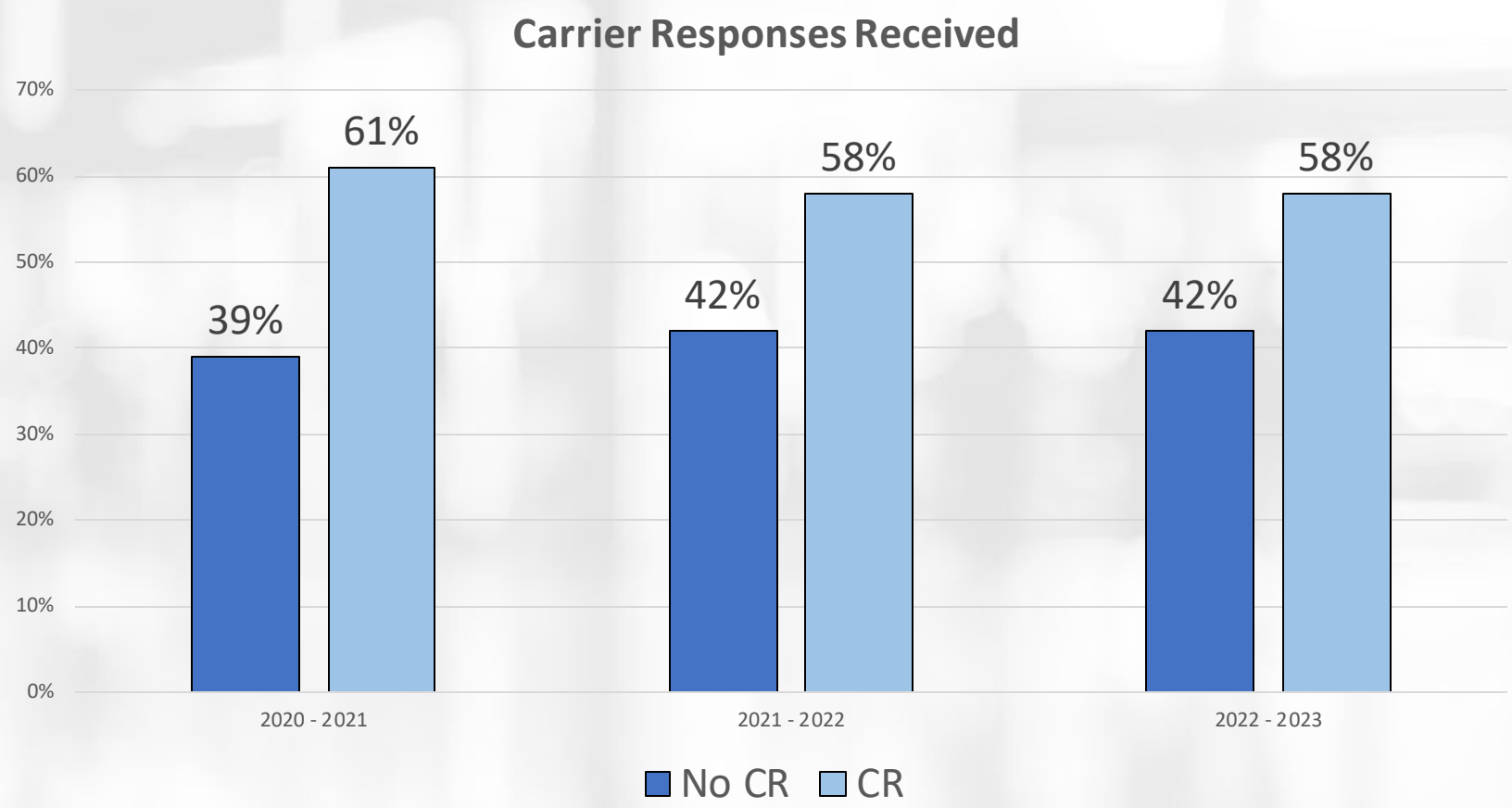
☐ **Verifiable Login Process** (a copy of the applicable portion of the login roster showing a date of login of the Notice of Disallowance or Adjustment will be accepted as proof of receipt through a verifiable login process).

☐ **Postmark Date** (a copy of the envelope in which the Notice of Disallowance or Adjustment was sent which clearly and legibly shows the postmark date will be accepted as proof of receipt by postmark date).

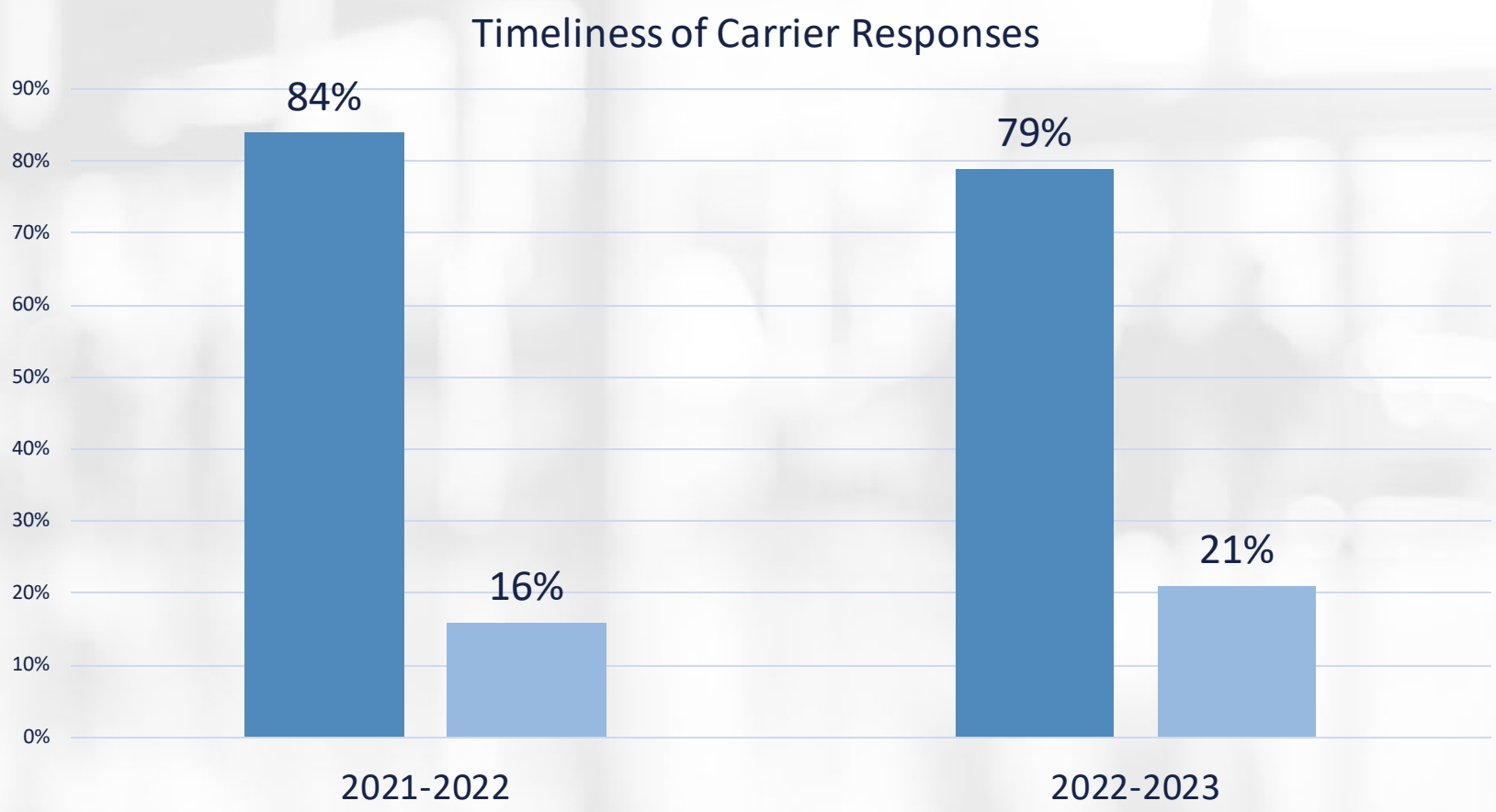
# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.

- Responses to NODs
  - Slightly over 60% of Petitioner NODs mailed by the Division received NO response
  - Must respond and cure within 20 days
  - Can be sent to the Division by email, US mail, or other delivery service
  - Provide proof of service to the Division

# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.



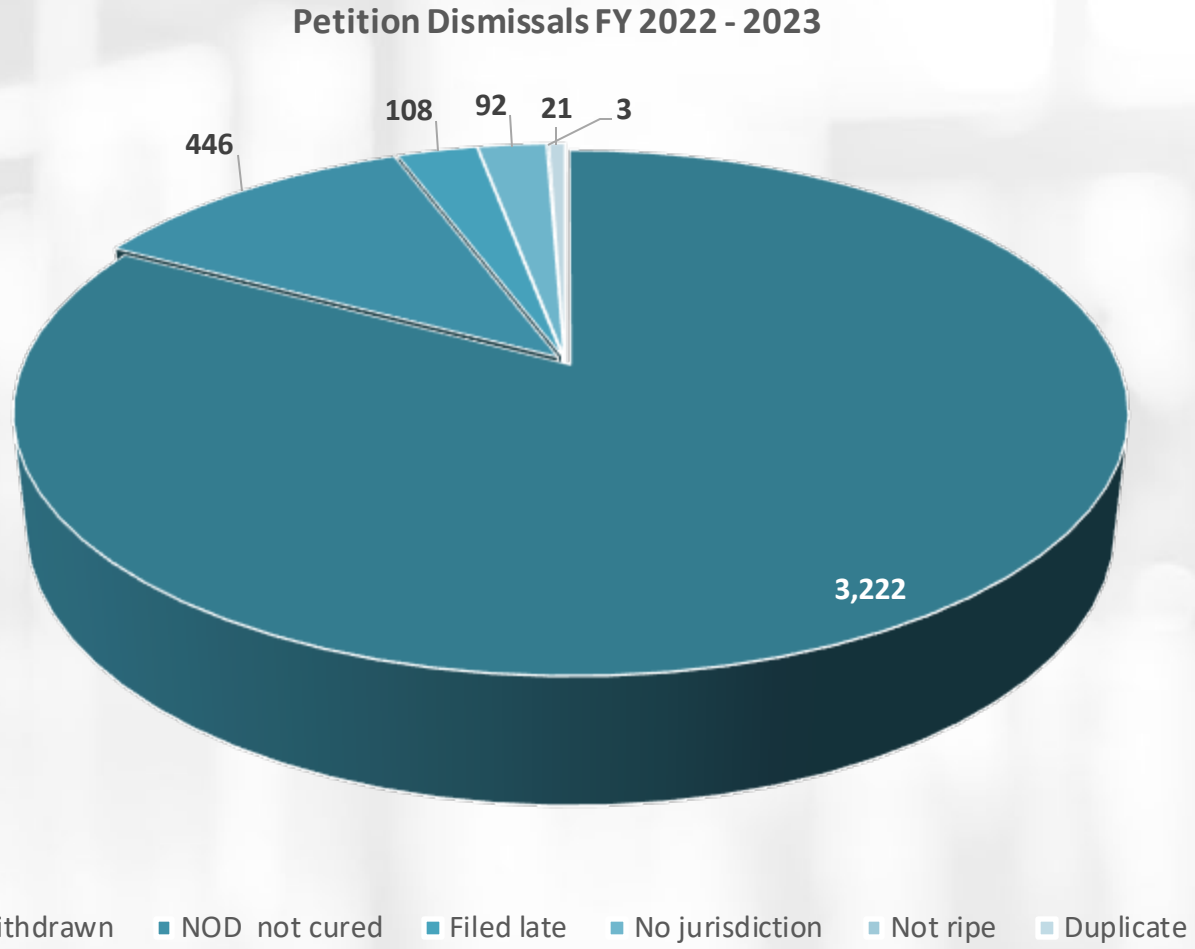
# Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.



# Utilization and Reimbursement Dispute Rule

## 69L-31, F.A.C.

## Total: 3,892



# Carrier Report of Health Care Provider (HCP) Violations Rule 69L-34, F.A.C.

- Investigation and determination of healthcare provider utilization patterns, billing practices, or violations of law or rules that may require penalties
- Effective September 06, 2011

| | | |
|---|---|---|
| 69L-34.001 Definitions | 69L-34.003 Mandatory Carrier Reporting | 69L-34.004 Elective Referral of Alleged Health Care Provider Violation |
| 69L-34.005 Timeliness of a Referral | 69L-34.005 Referral Investigation | 69L-34.006 Invalid Referrals |

# Carrier Report of Health Care Provider (HCP) Violations Rule 69L-34, F.A.C.

General Violation types:

- Improper Billing of Services
- Improper Reporting of Services
- Standards of Care Violation, including overutilization
- Failing to refund an overpayment or collecting payment from an injured worker

Referral Submission Types:

- Manual: Form DFS-F6-DWC-2000, Health Care Provider Violation Referral
- Health Care Provider Violations website: https://apps8.fldfs.com/hcprov/default.aspx

# Carrier Report of Health Care Provider (HCP) Violations Rule 69L-34, F.A.C.

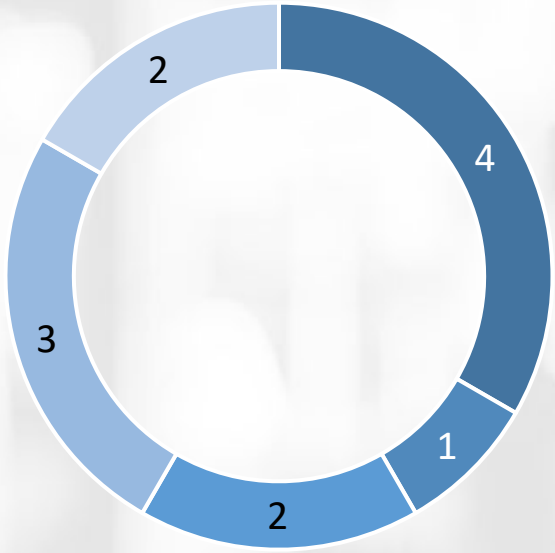
- Must be submitted to the Division no later than 180 days after the issuance of an EOBR or other notice of alleged violation
- Must be served on HCP
- Include all supportive documentation of the specific violation:
  - Proof of service on HCP
  - Supporting medical evidence
  - Correspondence and written requests between carrier and provider regarding the issue
  - Copies of medical bills and DWC-25 forms
  - Copies of Notices of Disallowance or Adjustment
  - Peer review reports
  - Copies of collection letters
  - Determinations issued by the Division

# Carrier Report of Health Care Provider (HCP) Violations Rule 69L-34, F.A.C.

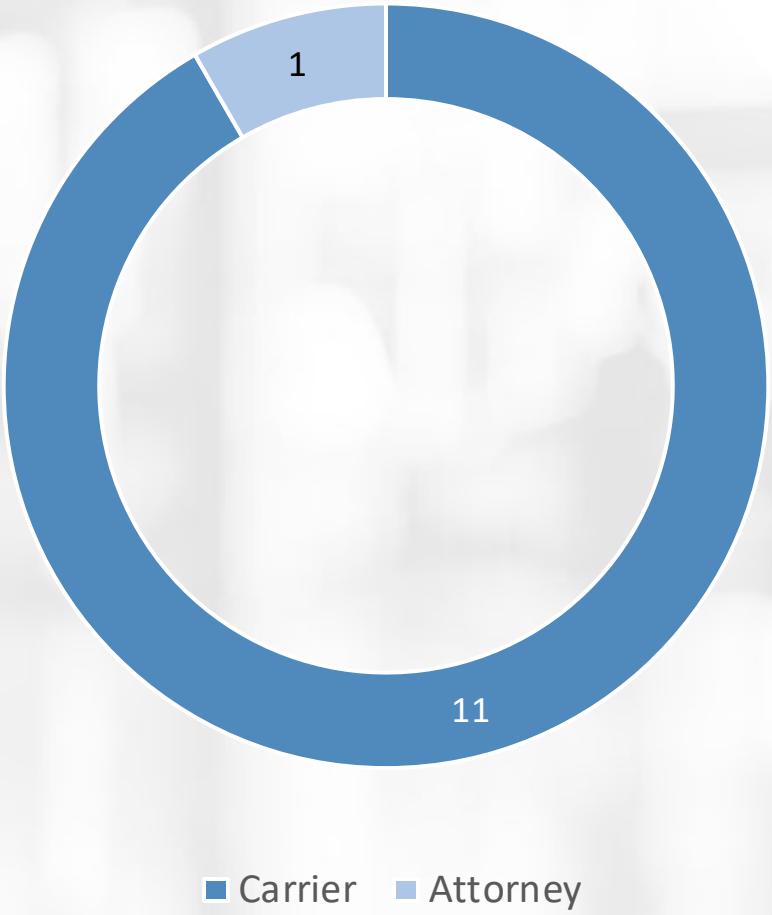
Incomplete reports:

- Many only contained the DFS-F6-DWC-2000, Health Care Provider Violation Referral form
  - We will reach out and ask for supporting documentation
- Incomplete DFS-F6-DWC-2000, Health Care Provider Violation Referral forms
  - Often missing the name of the provider that performed the service
  - Only one violation type per form

# HCP Violation Breakdown: Referral by Violation Type Received in FYE 2023



# HCP Violation Breakdown: By Referral Type Received in FYE 2023



# Reimbursement Manuals

- Development of Workers' Compensation Reimbursement Manuals, in collaboration with the Three-Member Panel (3MP)

# Healthcare Provider Reimbursement Manual, Rule 69L-7.020, 2020 Edition, F.A.C.

- The 2020 edition was adopted October 2021 but was not ratified (est. over $8M)
- Sought ratification for this edition again in 2023
- The 2020 edition was ratified and was effective July 1, 2023

# Healthcare Provider Reimbursement Manual, Rule 69L-7.020, 2020 Edition, F.A.C.

- Removes dispensing fee for dispensed OTC
- Details what should be included in prior authorization documentation
  - Dates requested and received
  - Name of carrier or designated entity
  - Name of person authorizing the services
- Includes telemedicine reimbursement methodology
- Incorporates the 2020 Medicare Relative Value Units (RVUs)
- Adopts 2020 CPT and HCPC Level II codes

# 2023 Statutory Changes for Medical Services

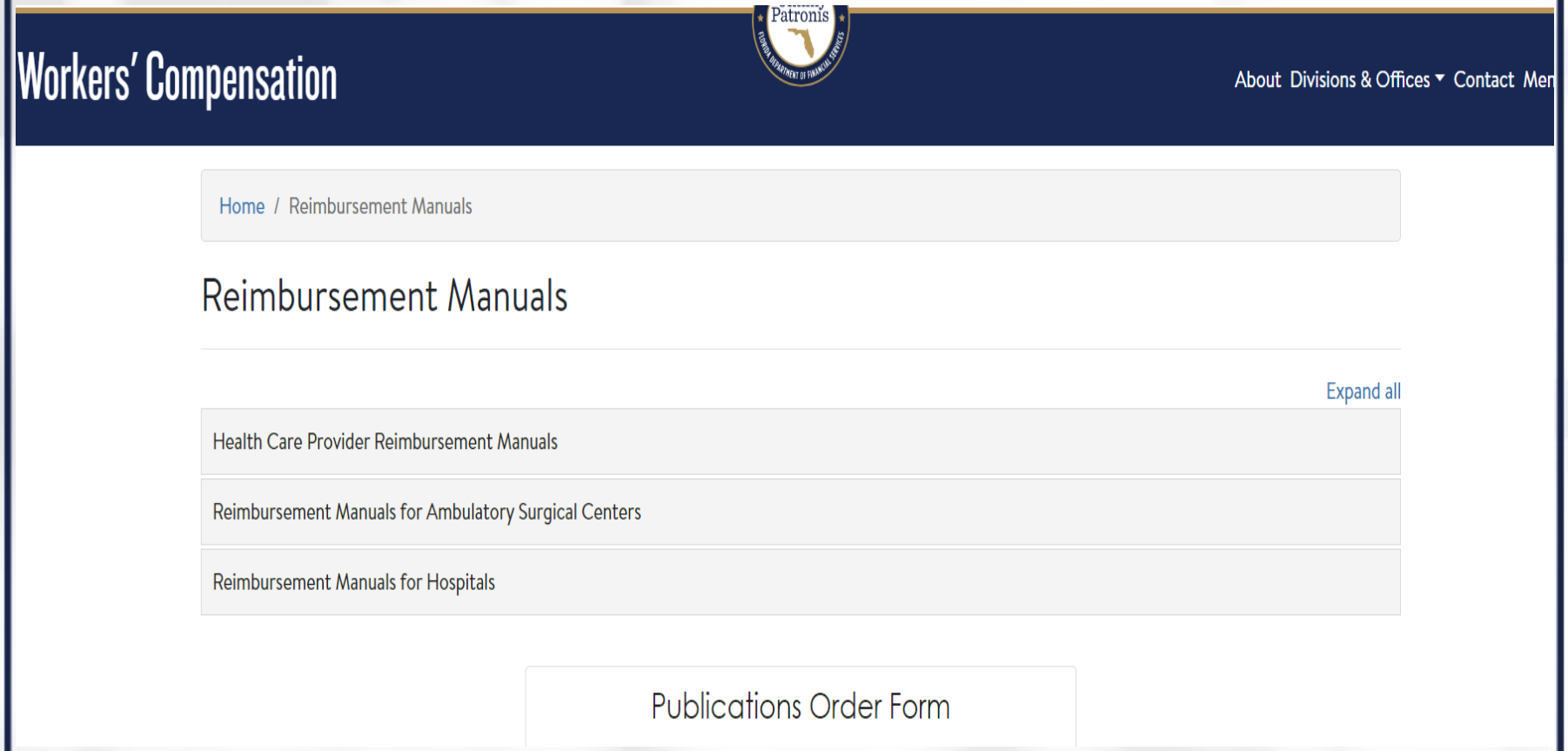
- HB 487 contained changes for determining schedules of MRAs for physicians removing them from the requirement of 3MP adoption of MRAs
- HB 487 also removed the 440.13(14) practice parameter requirement that mandated using the practice parameters adopted by the United States Agency for Healthcare Research and Quality

# Healthcare Provider Reimbursement Changes

- By July 1 of each year, the department shall notify stake holders of the schedule of MRAs for physicians and nonhospital services
- No longer subject to approval by 3MP
- MRAs will be published on the Division website

# Healthcare Provider Reimbursement Changes

## Locating physician MRAs schedules online:



# Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, 2020 Edition, F.A.C.

- Three-Member Panel meeting was last held in 2022
- Last hearing held in January 2023
- The 2020 edition became effective July 1, 2023

# Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, 2020 Edition, F.A.C.

Surgical Implant Reimbursement:

- According to an agreed upon contract price; or
- Thirty percent (30%) over the acquisition invoice cost

Associated Disposable Instrumentation for Surgical Implants:

- According to an agreed upon contract price; or
- Twenty percent (20%) over the acquisition invoice cost

# Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, 2020 Edition, F.A.C.

- Now contains two appendices containing MRA schedules
- Appendix A contains the maximum reimbursement amount for specific procedure codes
- Appendix B contains MRAs for ranges of procedure codes within the same anatomical subsystem that are not found in Appendix A

Appendix B — MRAs for CPT® Codes Not Listed in Appendix A

| CPT Code(s) | MRA | CPT Code(s) | MRA | CPT Code(s) | MRA |
|---|---|---|---|---|---|
| (10030-11646) | $1,598.00 | (44005-44799) | $2,911.00 | (95925-95939) | $949.00 |
| (11719-11765) | $761.00 | (45000-45999) | $1,152.00 | (95990-95999) | $600.00 |

# Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, 2020 Edition, F.A.C.

Bilateral Procedures Performed Unilaterally

- According to an agreed upon contract price; or
- Fifty percent (50%) of the MRA listed in Appendix A;
- Or if the billed CPT® code is not listed in Appendix A, fifty percent (50%) of the MRA listed in Appendix B.
- Bill using modifier 52

# Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, 2020 Edition, F.A.C.

Terminated Procedures (prior to anesthesia)

- According to an agreed upon contract price; or
- Fifty percent (50%) of the MRA listed in Appendix A; or
- If the billed CPT® code is not listed in Appendix A, fifty percent (50%) of the MRA listed in Appendix B
- Bill using modifier 73

# Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, 2020 Edition, F.A.C.

Terminated Procedures (after anesthesia)

- According to an agreed upon contract price; or
- The MRA listed in Appendix A of the comprehensive procedure; or
- If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B of the comprehensive procedure

- Procedures terminated prior to pre-op are not reimbursed

# Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, 2020 Edition, F.A.C.

All other procedures

- According to an agreed upon contract price; or
- The MRA listed in Appendix A; or
- If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B

# Hospital Reimbursement Manual
# Rule 69L-7.501, 2020 Edition, F.A.C.

- Last Three-Member Panel meeting held in April 2022
- Effective May 25, 2023

# Workers' Compensation Medical Reimbursement and Utilization Review, 69L-7 Rule Series

Medical services billing, filing, and reporting

| 7.710 - Definitions | 7.720 – Forms | 7.730 – HCP Billing & Reporting | 7.740 – Insurer Authorization and Bill Review | 7.750 – Insurer Medical Report Filing |
|---|---|---|---|---|

69L-7

# Workers' Compensation Medical Reimbursement and Utilization Review, 69L-7 Rule Series

- 69L-7.710: Definitions
  - No change
- 69L-7.720: Forms Incorporated by Reference for Medical Billing, Filing, and Reporting
  - No change
- 69L-7.750: Insurer Medical Report Filing
  - No change

# Workers' Compensation Medical Reimbursement and Utilization Review, 69L-7 Rule Series

69L-7.730: Health Care Provider Medical Billing, Filing and Reporting

- Effective July 1, 2023
- Physicians and recognized providers registered to dispense medications may dispense to injured workers
- Requests for authorization of medications to be dispensed:
  - Must specify drug name, dosage, and strength
  - Must be documented in injured worker's file
  - Must be sent in a manner prescribed by the carrier pursuant to 440.13(3)(e), F.S.

# Workers' Compensation Medical Reimbursement and Utilization Review, 69L-7 Rule Series

69L-7.740: Insurer Authorization and Medical Bill Reporting Responsibilities

- Effective July 1, 2023
- Medication is treatment
- Insurer may disallow dispensed medication if not authorized prior to dispensing and not medically necessary
- Responses to requests for authorization must be communicated electronically or by telephone and documented in the claims administration system

# Workers' Compensation Medical Reimbursement and Utilization Review, 69L-7 Rule Series

## Explanations of Bill Review

- Florida specific EOBR codes and descriptors
  - Internal reason codes may be appended in addition to Florida specific EOBR codes
  - Use the FL EOBR code that is the best fit for each line item
- Four types of EOBR Codes
  - Denied; disallowed; adjusted and paid; and paid
- Do not set a default EOBR
- Ensure EOBR is legible and nothing is cut off on the form

# Workers' Compensation Medical Reimbursement and Utilization Review, 69L-7 Rule Series

Reporting subsequent payments to the Division via Medical EDI

- All payments must be reported
  - In response to a reconsideration
    - Follow Reconsideration Scenarios for submitting bills via EDI
  - In response to a Division issued Determination or Final Order
    - EOBR Code 95 – Paid: Reimbursement Dispute Resolution: Payment made pursuant to receipt of a Determination or Final Order on a Petition.

# Selected Materials Incorporated by Reference, 69L-8 Rule Series

Rule Chapter 69L-8 currently contains the following:

- 69L-8.071: Materials for use with the Florida Workers' Compensation Health Care Provider Reimbursement Manual
- 69L-8.072: Materials for use with the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers
- 69L-8.073: Materials for use with the Florida Workers' Compensation Hospital Reimbursement Manual
- 69L-8.074: Materials for use throughout Rule Chapter 69L-7, F.A.C.

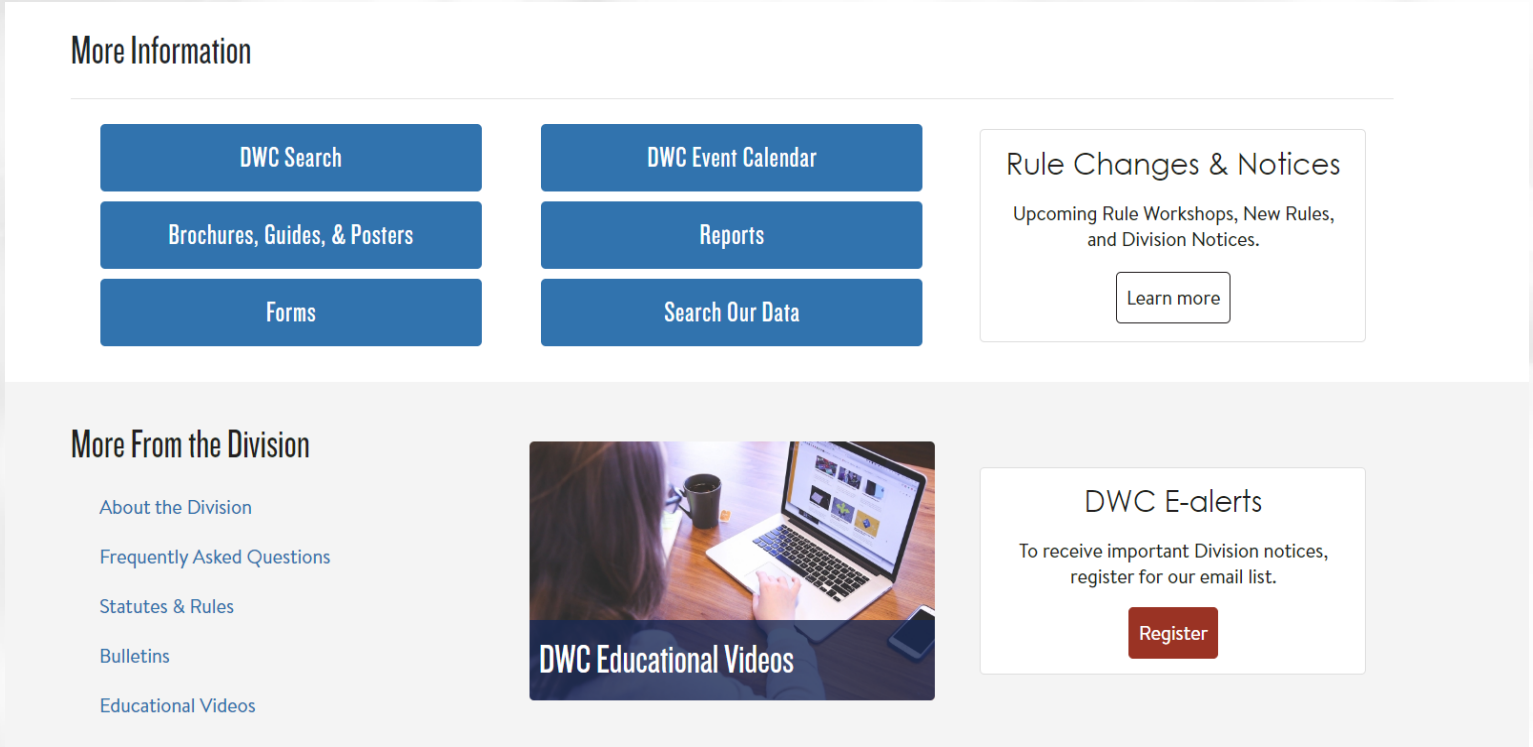
# Selected Materials Incorporated by Reference, 69L-8 Rule Series

- 69L-8.071 and 69L-8.074
  - Effective January 18, 2018
- 69L-8.072 and 69L-8.073
  - Effective February 18, 2016
- The contents of these rules have been moved to the individual reimbursement manual rule texts
- We will begin repealing this rule series

# DWC E-Alerts

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

Receive email notifications from the FL Division of Workers' Compensation regarding regulatory activities impacting the workers' compensation system



**Customer Assistance**

**850-413-1613**

**workers.compmedservice@myfloridacfo.com**

# Medical Services Section
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# Contact Information

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# Questions

DEPARTMENT OF FINANCIAL SERVICES


CFO JIMMY PATRONIS