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

CFO JIMMY PATRONIS

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

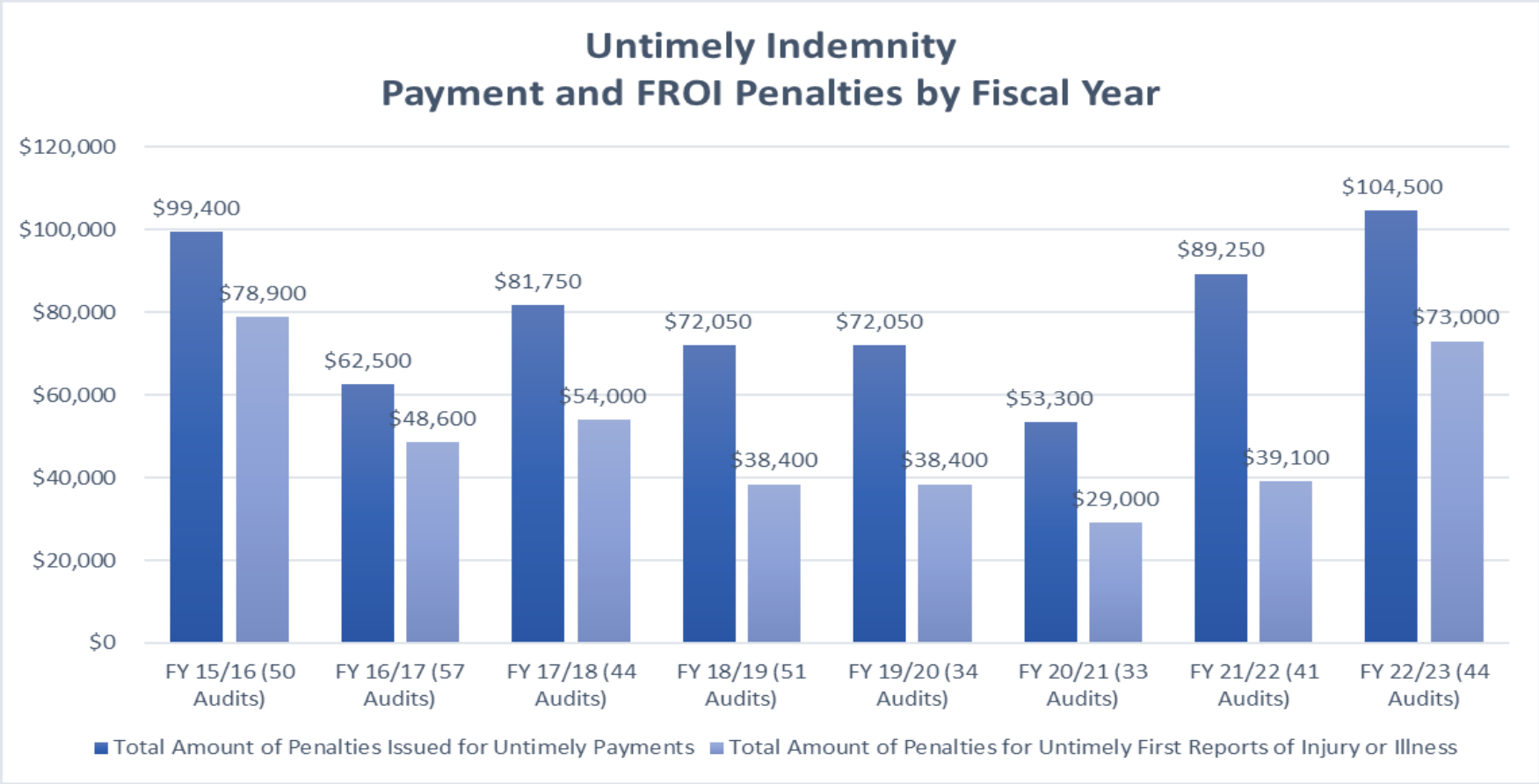
FY 2021-2022

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”.

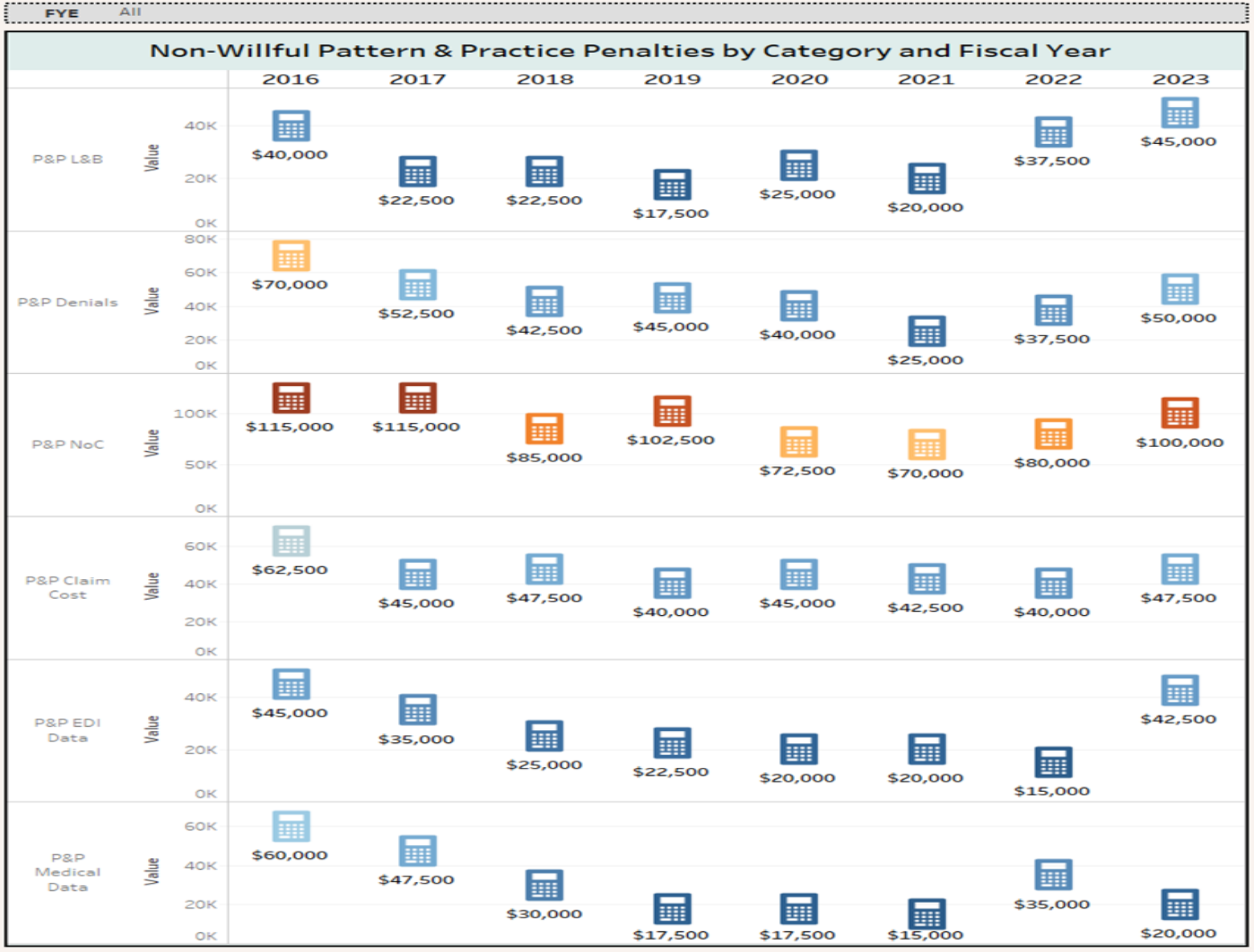
- When determining the compensation rate, the calculated amount should be:
  - 66 2/3% or
  - 66.67

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)

DEPARTMENT OF FINANCIAL SERVICES



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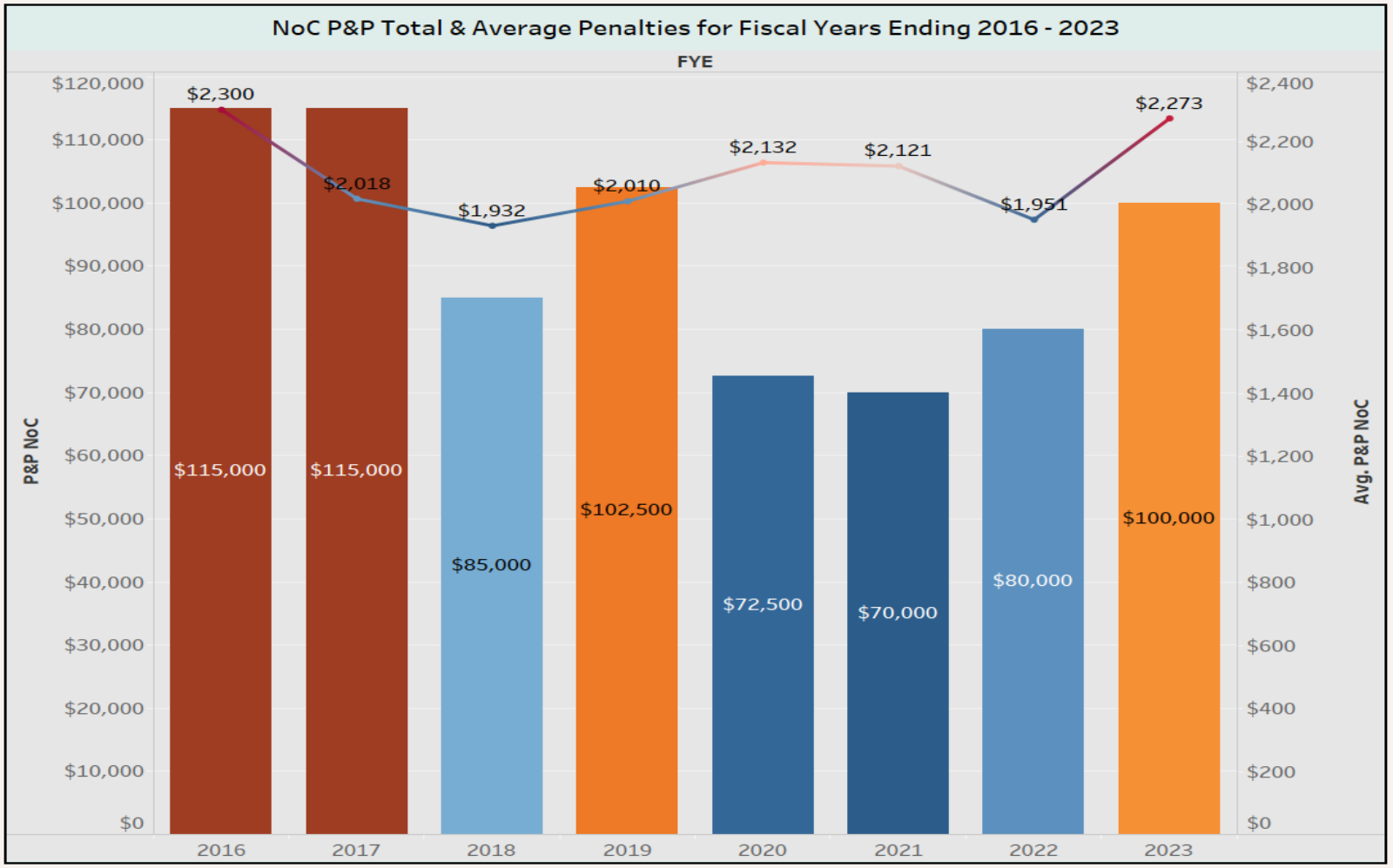
Auditing Notice of Action or Change Compliance

- 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

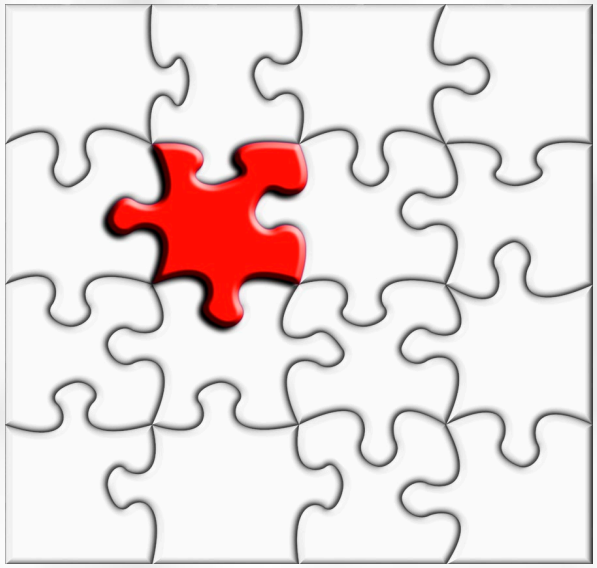
Insurer Reporting Services Section (IRSS)

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)

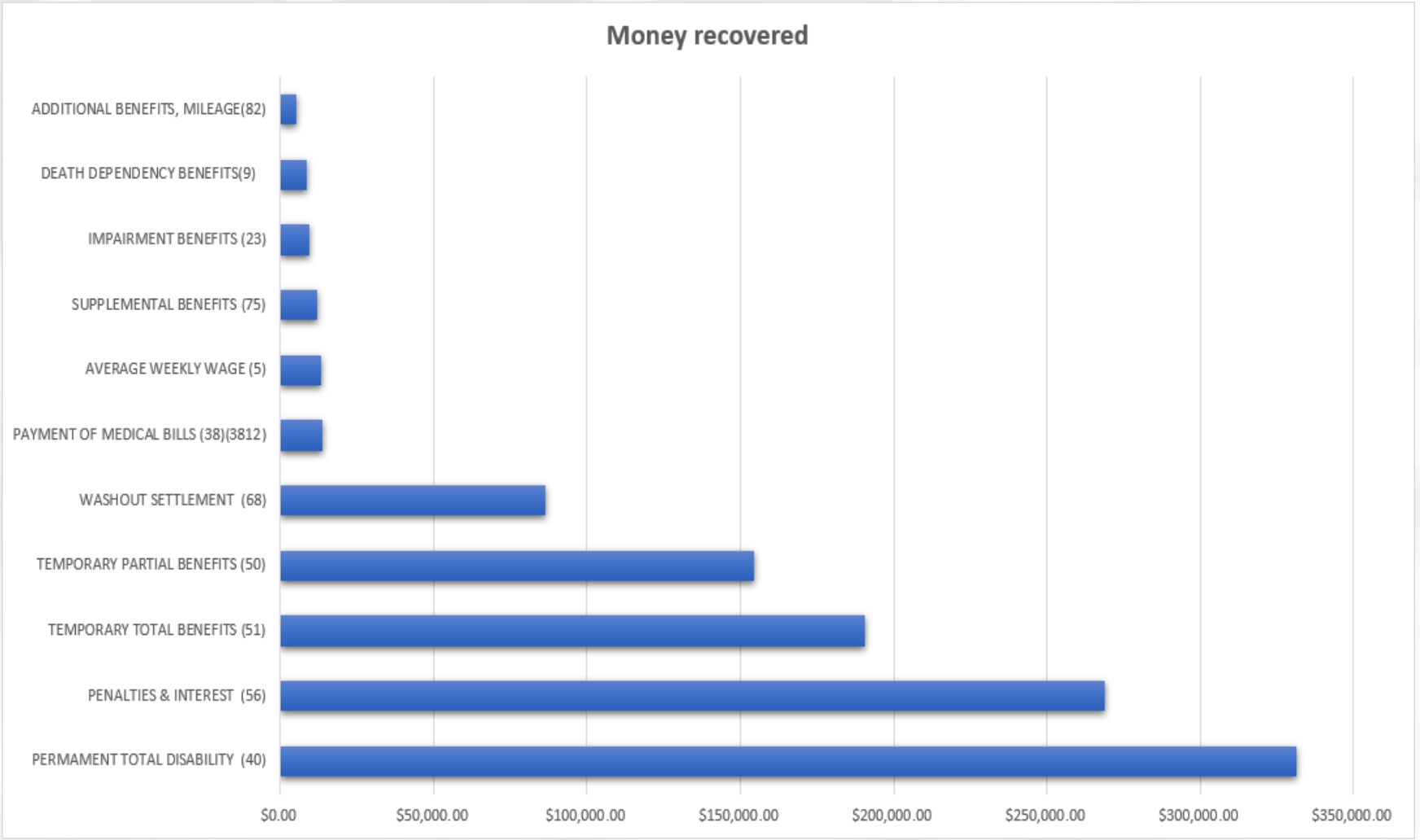
Injured Worker Workshop (Spanish)

Our Roles & Responsibilities

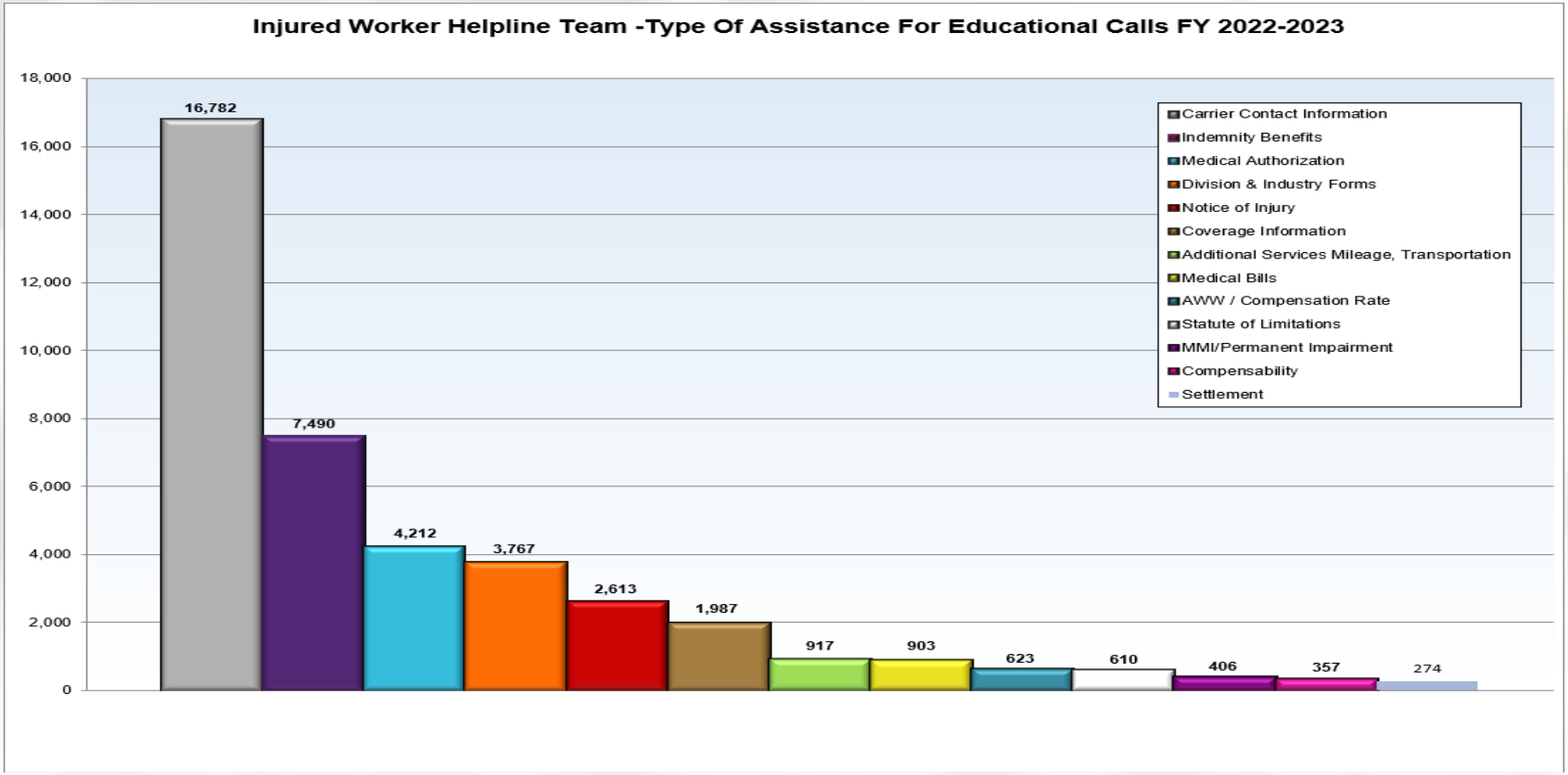
Employee Assistance & Ombudsman(EAO)

- 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

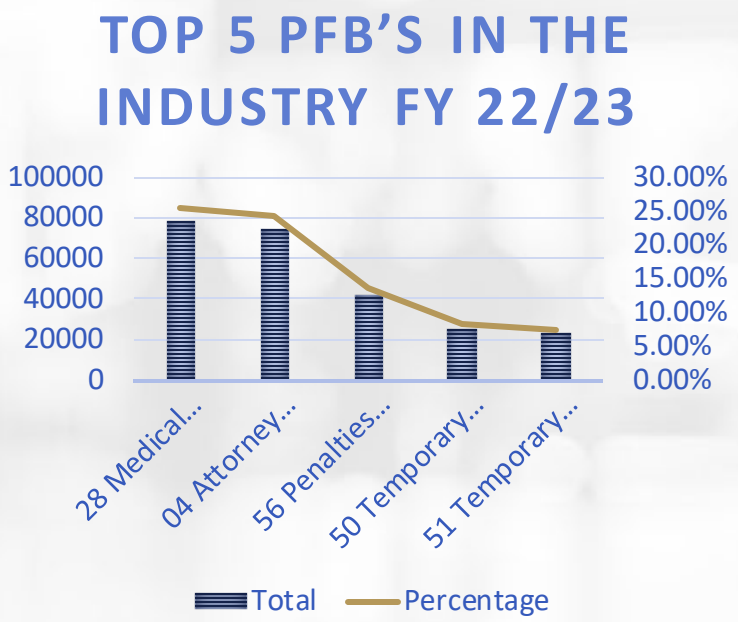


Employee Assistance & Ombudsman(EAO)



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

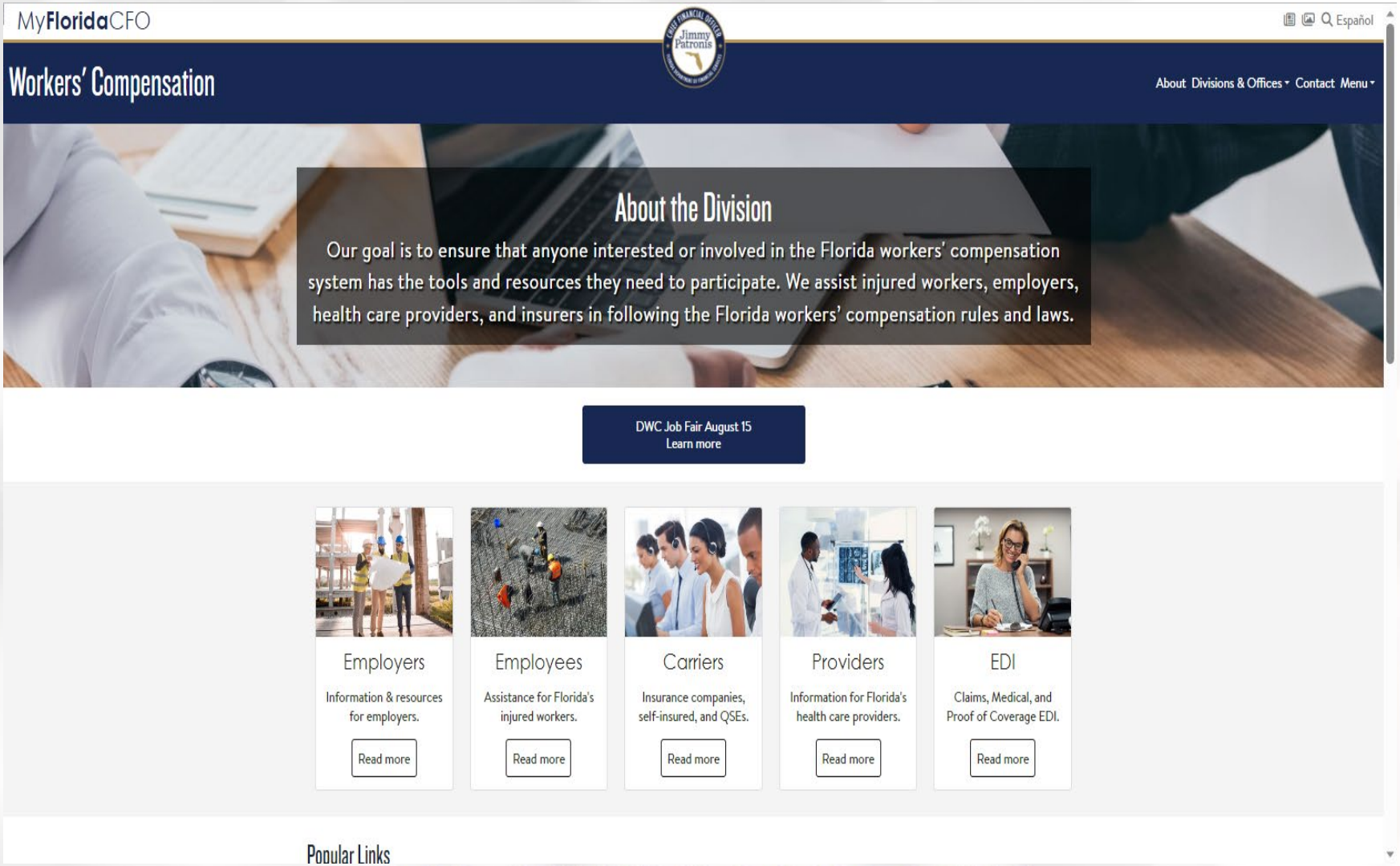
Sr. Management Analyst Supervisor – Customer Service Team

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

Medical Services Section Update

Theresa Pugh
Program Administrator
Medical Services Section

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.

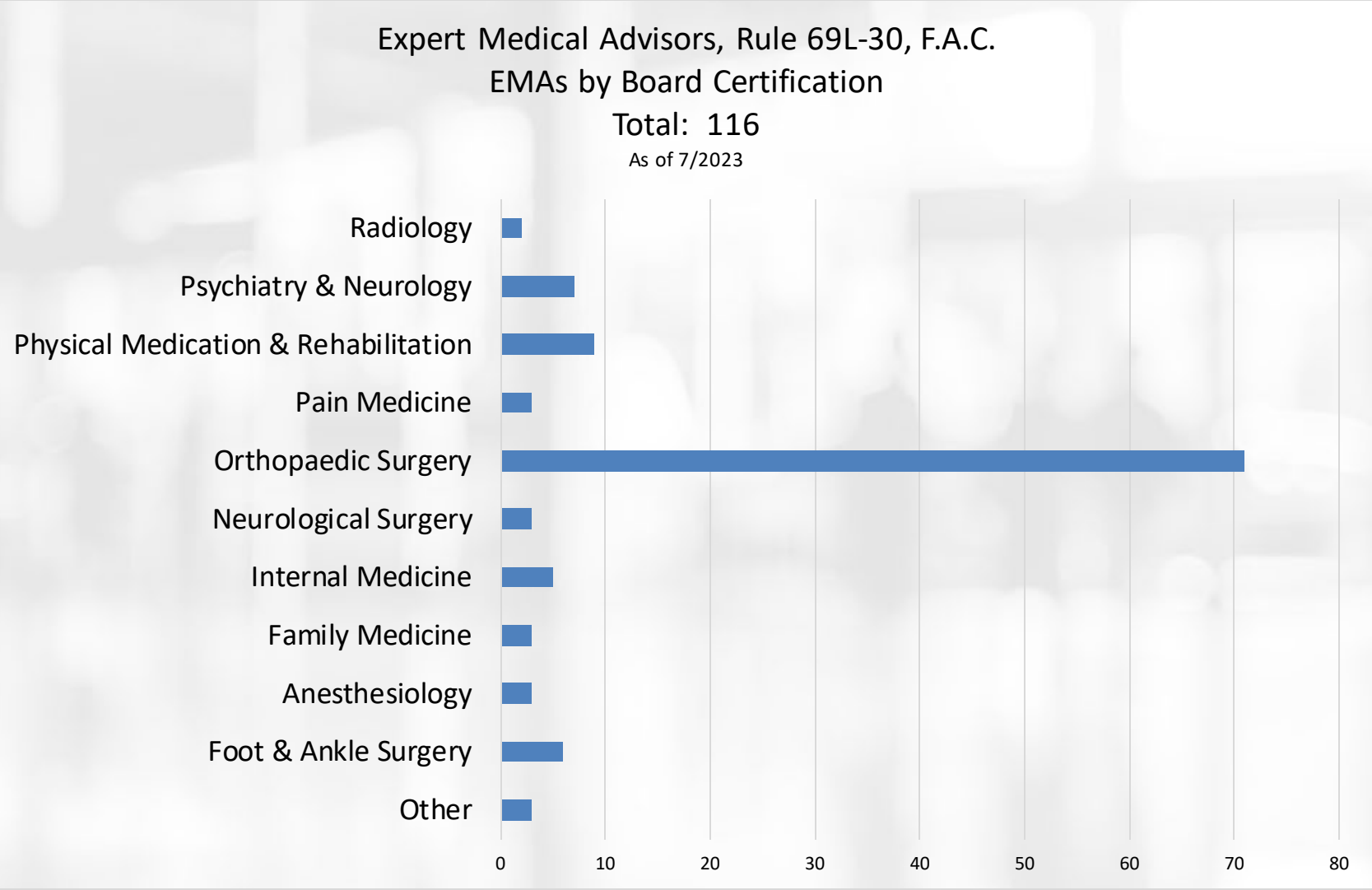
- Covers Expert Medical Advisor certification and Expert Medical Advisor database maintenance
- In effect since May of 2017
- No changes, however, pursuing additional avenues for increasing EMA enrollment

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

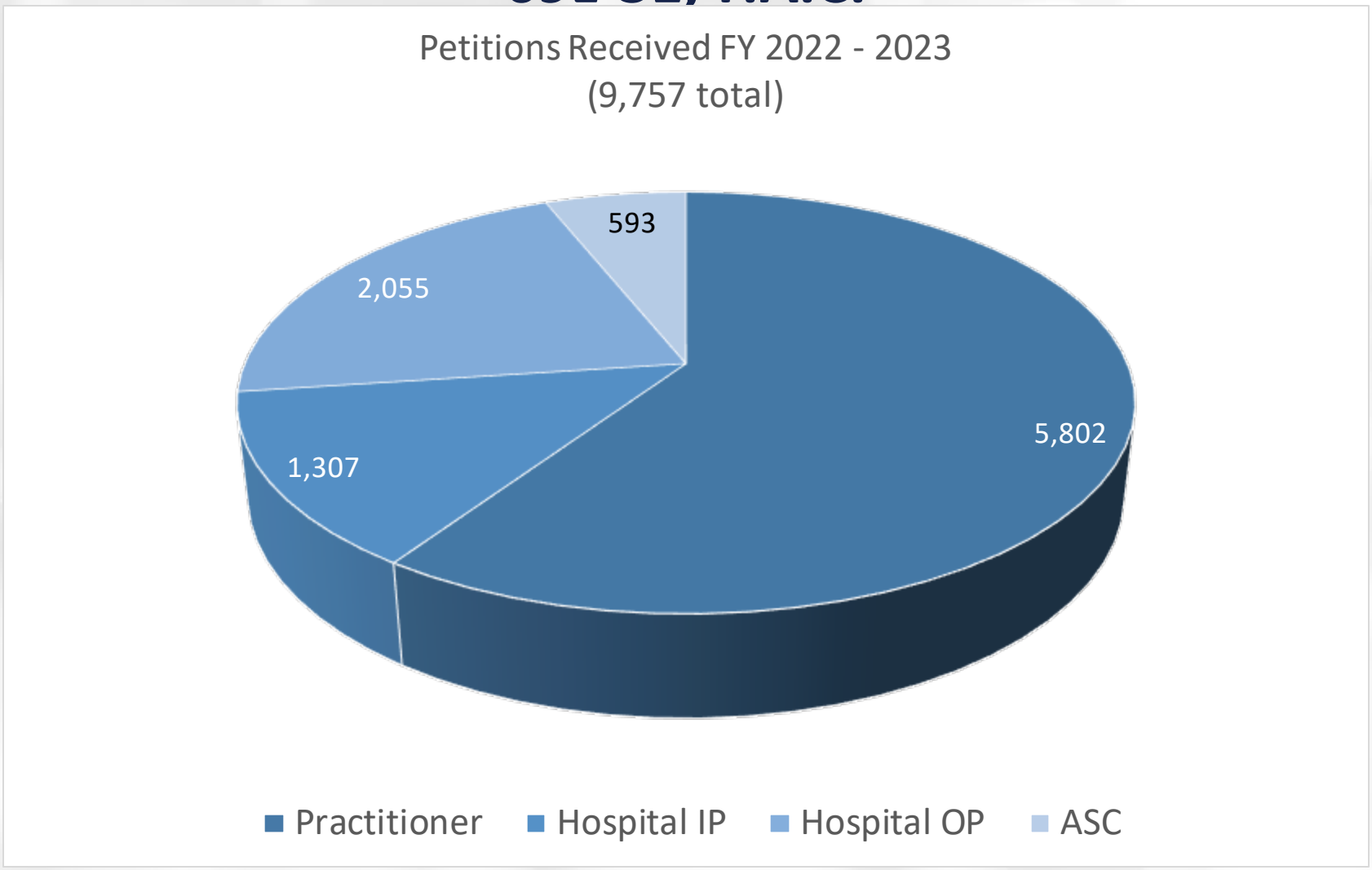
69L-31.008
Computation of Time

69L-31.013
Petition Withdrawal

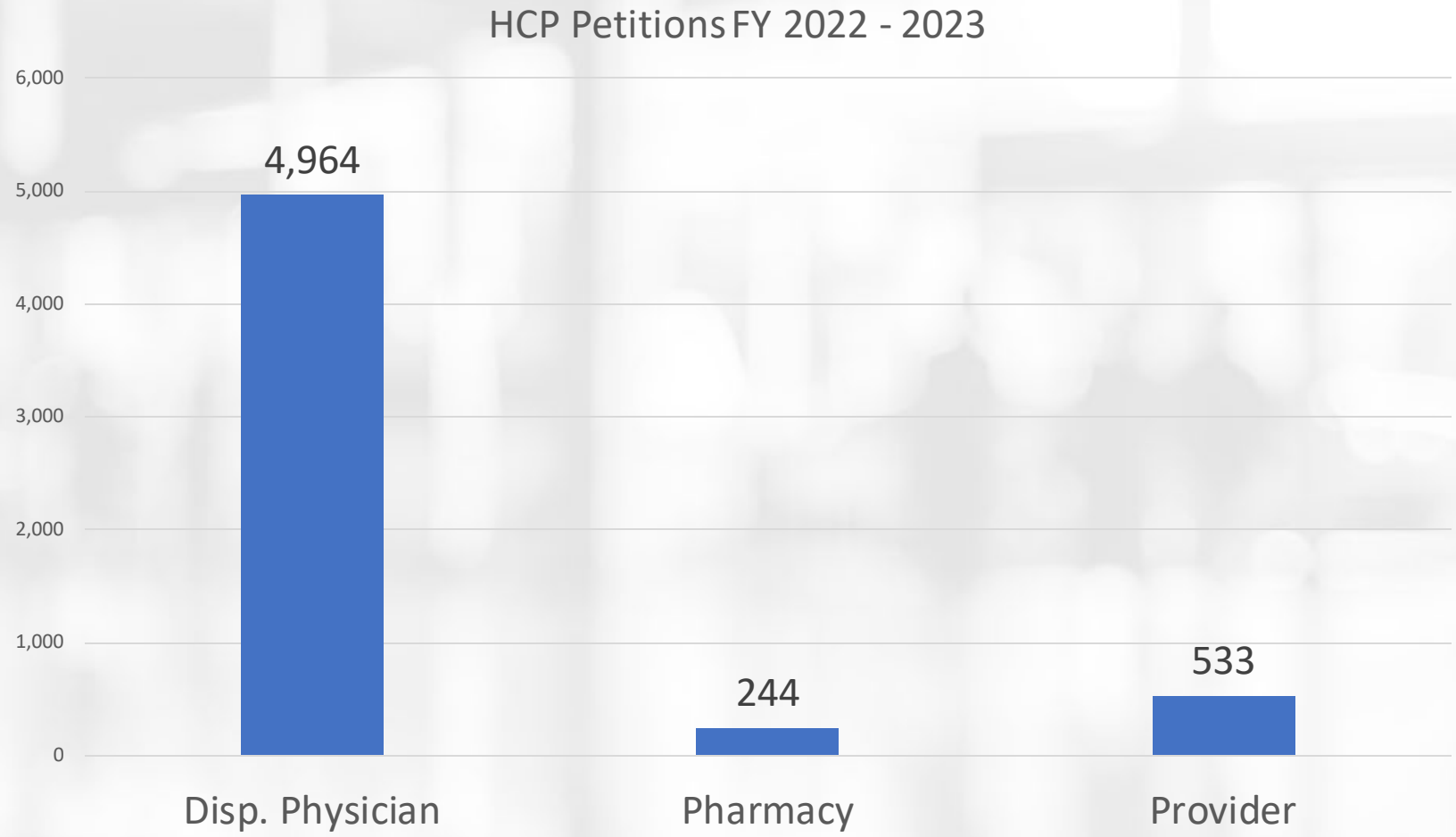
Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.

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

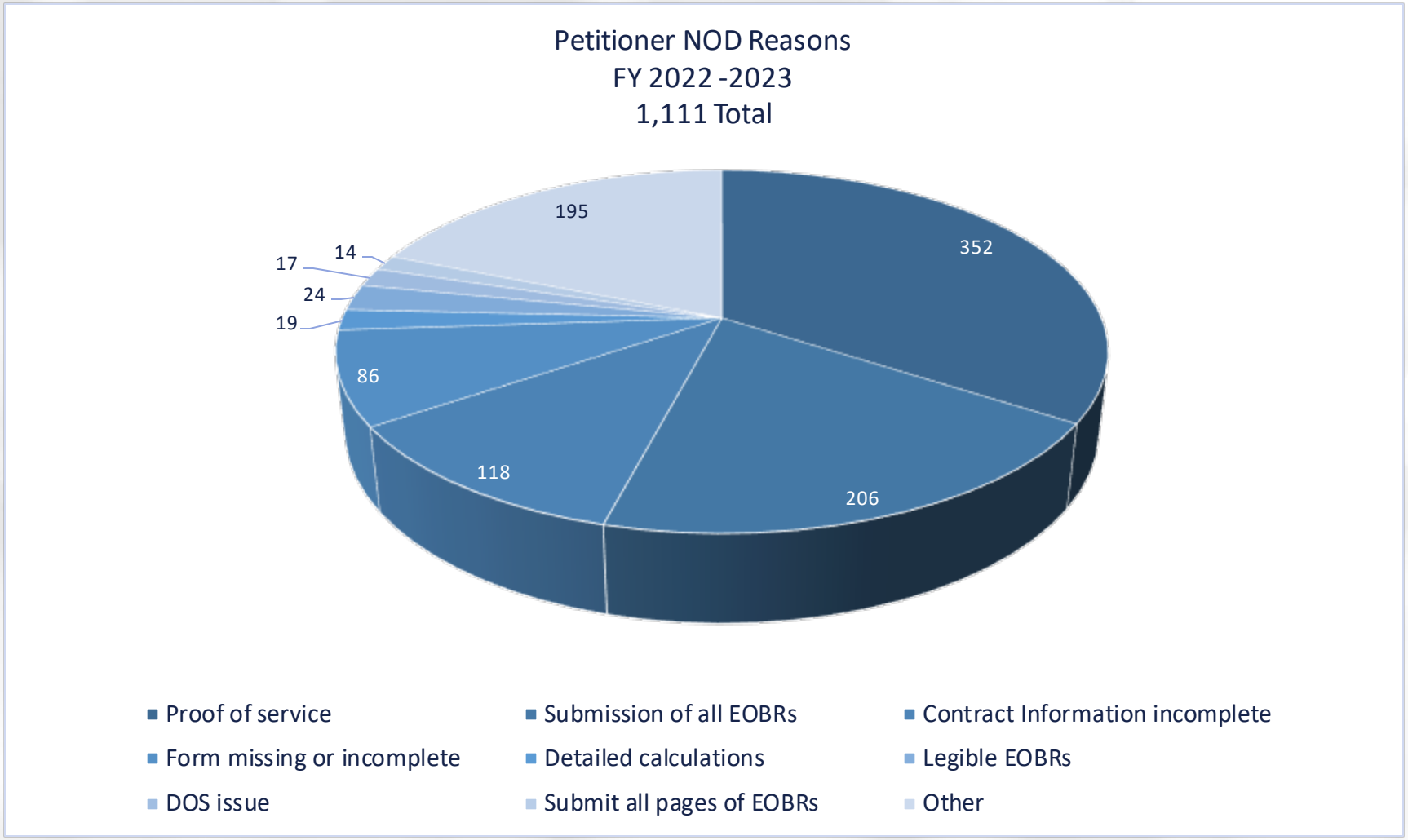
Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.



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).

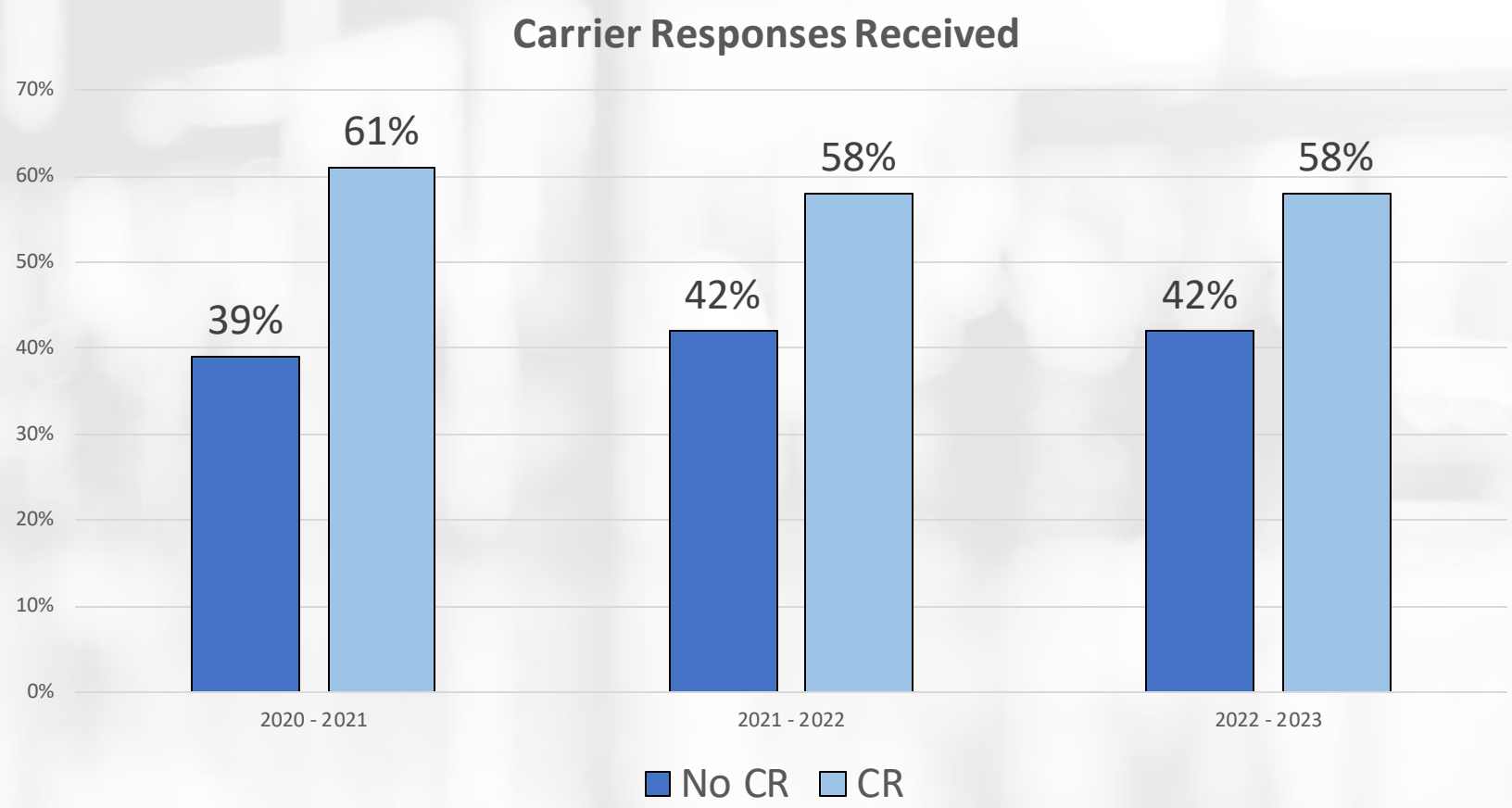
☐ **Verifiable Login Process** (a copy of the applicable portion of the login roster showing a date of login of the Notice of Disallowance or Adjustment will be accepted as proof of receipt through a verifiable login process).

☐ **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).

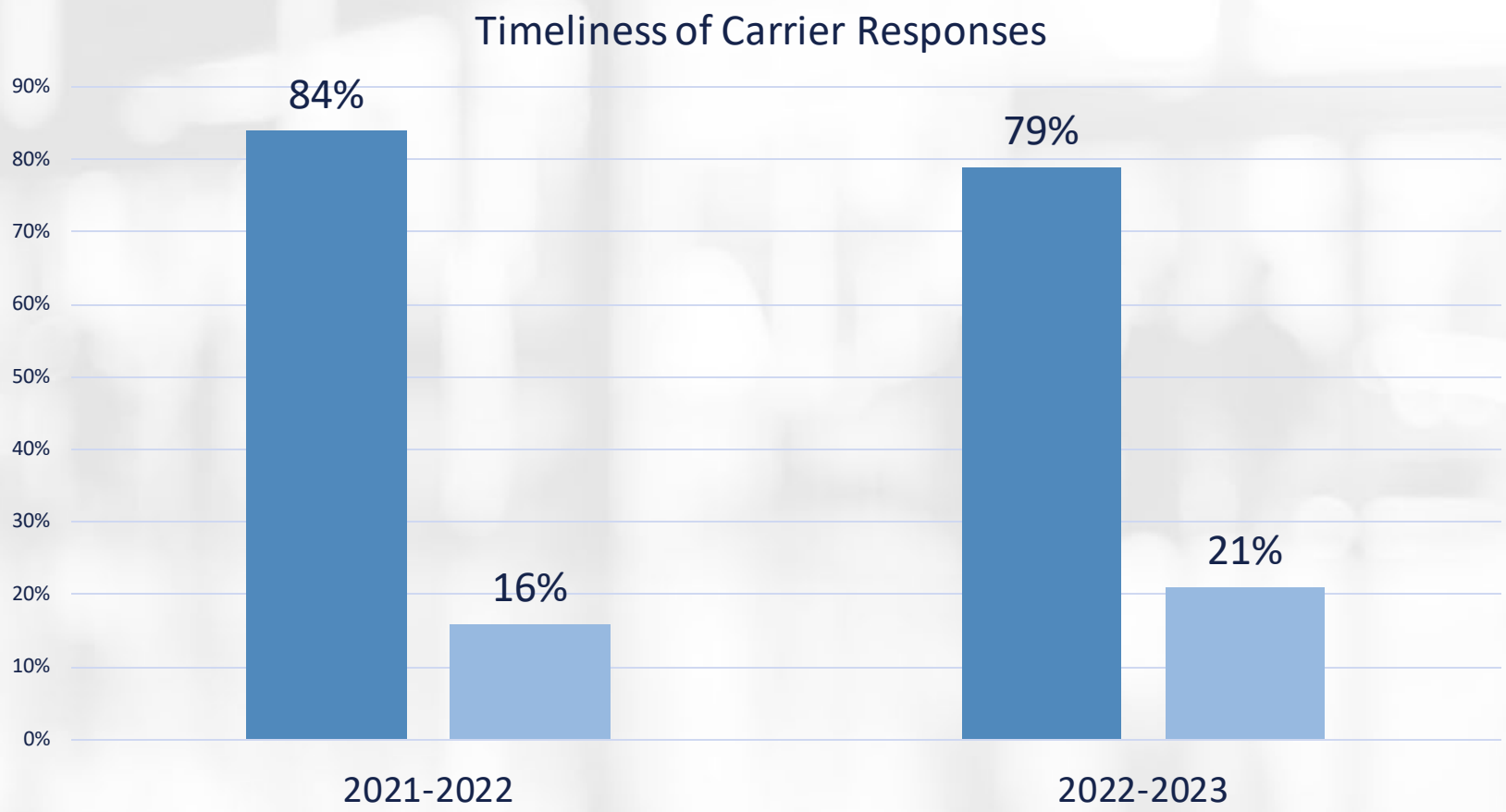
Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.

- 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.



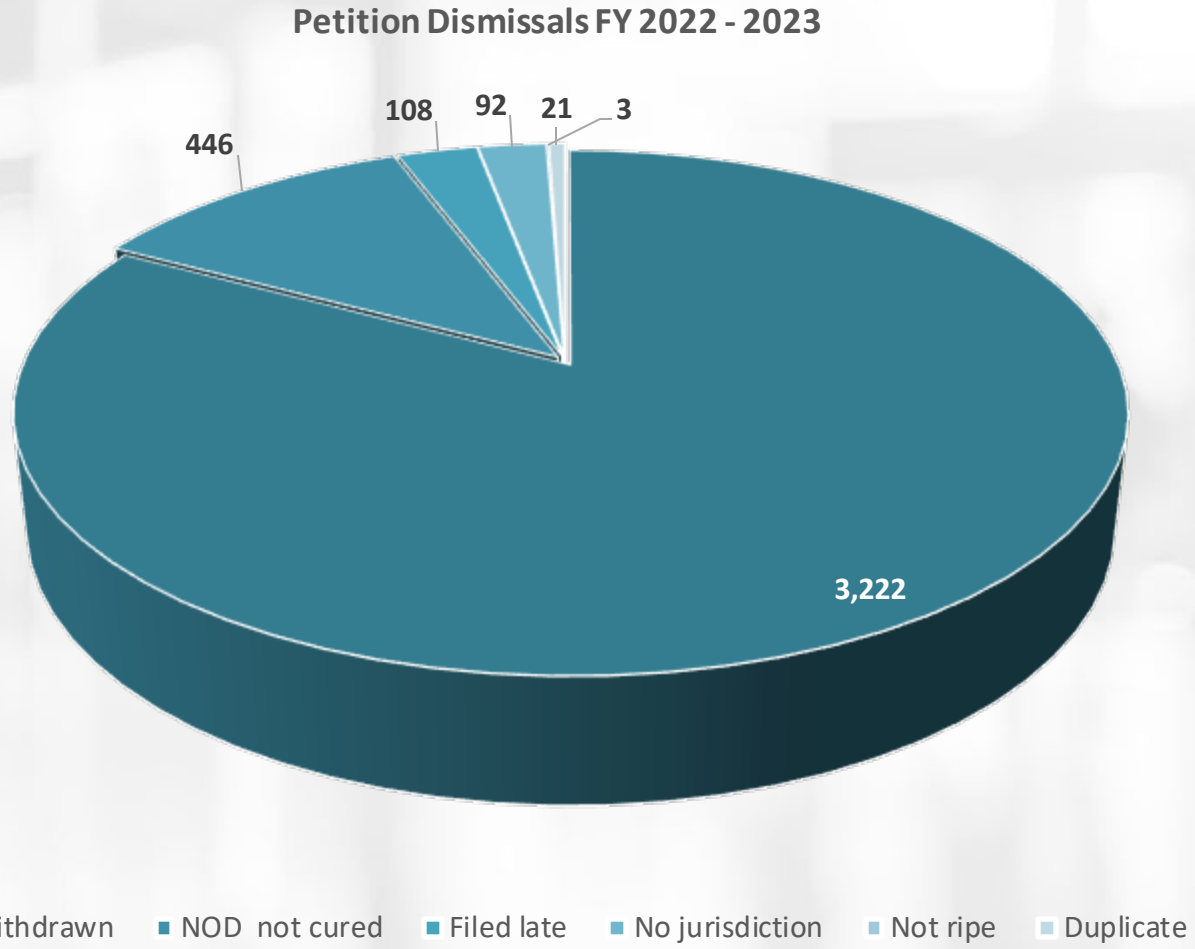
Utilization and Reimbursement Dispute Rule, 69L-31, F.A.C.



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.

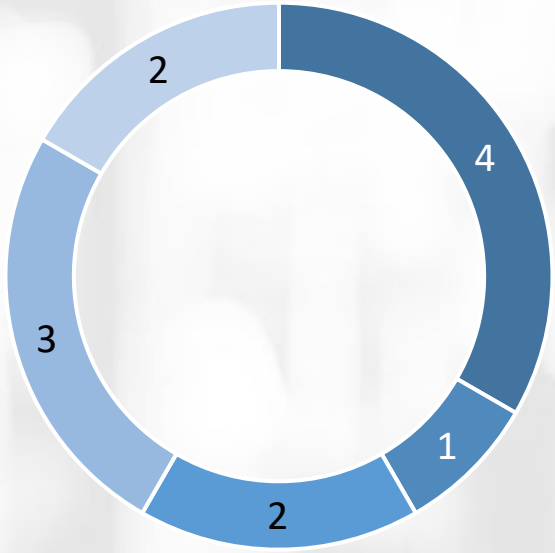
- Must be submitted to the Division no later than 180 days after the issuance of an EOBR or other notice of alleged violation
- Must be served on HCP
- Include all supportive documentation of the specific violation:
  - Proof of service on HCP
  - Supporting medical evidence
  - Correspondence and written 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.

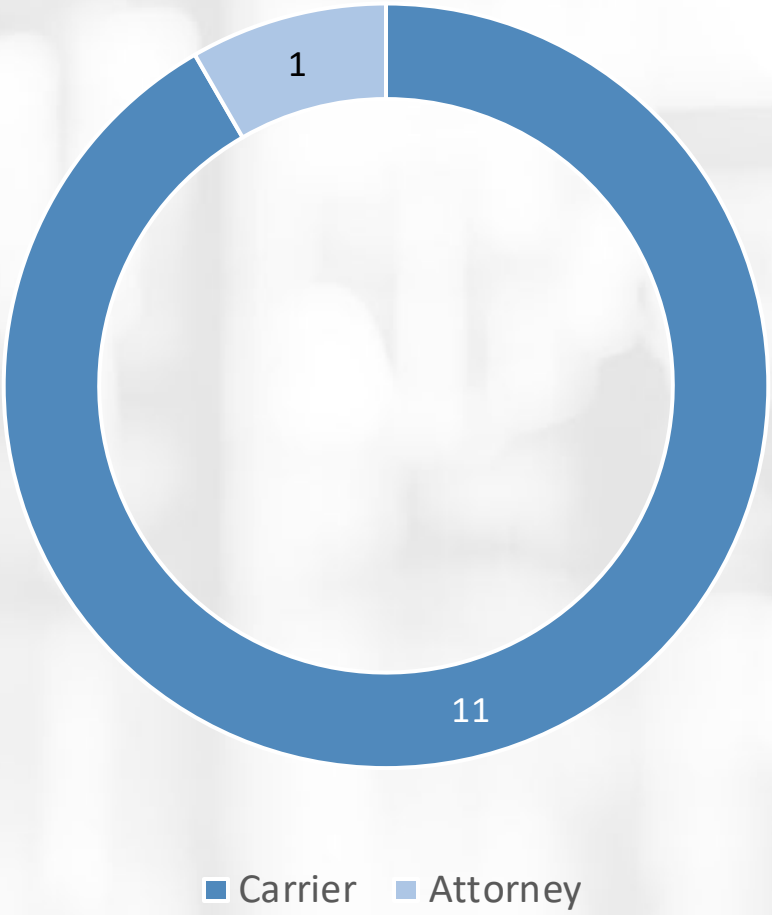
Incomplete reports:

- 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

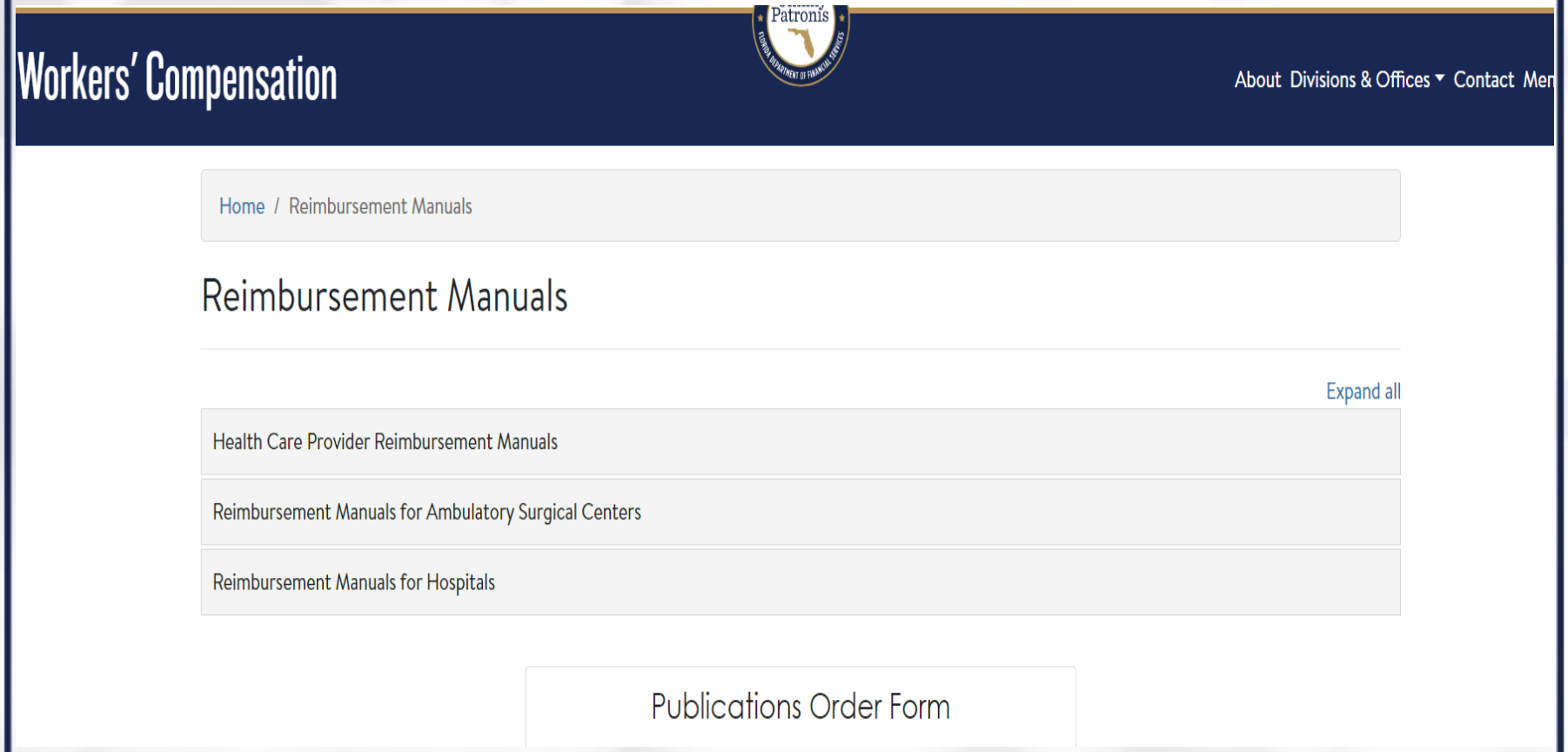
- HB 487 contained changes for determining schedules of MRAs for physicians removing them from the requirement of 3MP adoption of MRAs
- HB 487 also removed the 440.13(14) practice parameter requirement that mandated using the practice parameters adopted by the United States Agency for Healthcare Research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

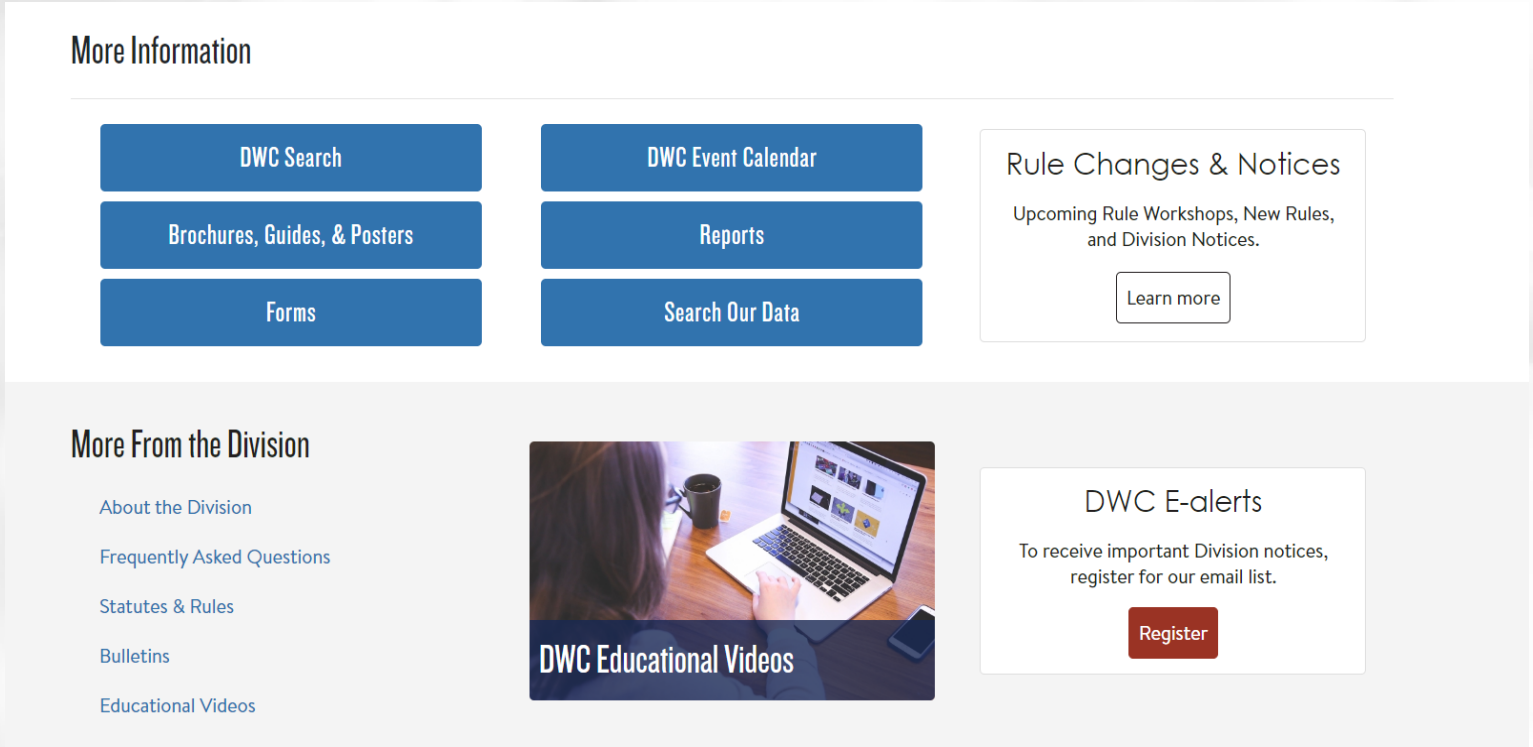
Selected Materials Incorporated by Reference, 69L-8 Rule Series

- 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

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Questions

DEPARTMENT OF FINANCIAL SERVICES

CFO JIMMY PATRONIS