RULE HEARING RELATING TO

PROPOSED RULE 69L-7.740, F.A.C.

Insurer Authorization and Medical Bill Review Responsibilities

STATE OF FLORIDA, DEPARTMENT OF FINANCIAL SERVICES

Wednesday, January 13, 2021

9:30 A.M.

*** THIS PROCEEDING IS OPEN TO THE PUBLIC VIA PHONE AND ONLINE***

You may join the meeting from your computer, tablet or smartphone at the time of the meeting.
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1. Call to order.

2. Opening remarks by the Presiding Officer.

3. Presentations by any affected persons, or evidence and argument on all issues under consideration relating to the proposed adoption of Rule 69L-7.740, F.A.C., appropriate to inform the Department of Financial Services of their contentions pursuant to the provisions of section 120.54, F.S., regarding hearings.

4. Concluding remarks by the Presiding Officer.

5. Adjournment.

CHAPTER 69L-7
WORKERS' COMPENSATION MEDICAL REIMBURSEMENT AND UTILIZATION REVIEW

69L-7.740 Insurer Authorization and Medical Bill Review Responsibilities

69L-7.740 Insurer Authorization and Medical Bill Review Responsibilities.

(1) An insurer is responsible for meeting its obligations under this rule regardless of any business arrangements with any claim administrator or any entity acting on behalf of an insurer under which medical bills are paid, adjusted, disallowed, denied, or otherwise processed or submitted to the Division.

(2)(a) At the time of authorization for medical service(s) or upon receipt of notification of emergency care, an insurer shall notify each health care provider, in writing, of data elements or supporting documentation necessary for reimbursement determinations that are in addition to the requirements of this rule and the applicable reimbursement manual.

(b) This subpart applies to dates of injury occurring on or after October 1, 2003. At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall issue a written or electronic notice to each health care provider stating whether the insurer will, when paying reimbursement for the medical service(s) for a compensable injury, apportion out the percentage of need for the care attributable to a pre-existing condition pursuant to subsection 440.15(5), F.S. If the insurer decides to apportion out the percentage of need for the care attributable to the pre-existing condition after authorization, the insurer shall issue a written or electronic notice to each health care provider stating that the insurer will apply such apportionment, pursuant to subsection 440.15(5), F.S., to the reimbursement for the authorized medical service(s). Compliance with this subpart is independent of and does not satisfy the notification requirement pursuant to rule 69L-3.017, F.A.C.

(3) At the time of authorization for medical service(s), or upon receipt of notification of emergency care, an insurer shall inform out-of-state health care providers of the specific reporting, billing and submission requirements contained in rule 69L-7.730, F.A.C. (Health Care Provider Responsibilities), and provide in-state and out-of-state health care providers the specific address for submitting a reimbursement request.

(4) Claim administrators or entities acting on behalf of insurers and health care providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of an injured employee's medical treatment/status and for requesting approval of a treatment plan. No other reporting forms may be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

(5) Required data elements on each electronic form equivalent of Form DFS-F5-DWC-9, DFS-F5-DWC-10, DFS-F5-DWC-11, and DFS-F5-DWC-90, for both medical only and lost-time cases, shall be filed with the Division within 45 days of when the medical bill is paid, adjusted, disallowed or denied by the insurer, claim administrator or any entity acting on behalf of the insurer. The 45 day filing requirement includes initial submission and correction and re-submission of all errors identified in the "Medical Bill Acknowledgement," as defined in the MEIG.

(6) An Insurer shall be responsible for accurately completing required data filed with the Division, pursuant to the MEIG and rule 69L-7.750, F.A.C. Additionally, an insurer or entity acting on behalf of an insurer shall be responsible for correcting previously accepted data that is deemed inaccurate by the Division through monitoring, auditing, investigation or analysis, and resubmitting the corrected and accurate data in accordance with the requirements set forth in the MEIG and subsection 69L-7.750(5), F.A.C. Failure by the Insurer to correct inaccurate data may result in penalties pursuant to s. 440.525, F.S.

(7) When an injured employee does not have a Social Security Number ~~or a previously assigned Division-Assigned Number~~, the claim administrator or entity acting on behalf of the insurer shall contact the Division via email at DWCAssignedNumber@myfloridacfo.com to obtain a Division-Assigned Number (DAN) to serve as the employee's interim numerical identifier until the social security number is obtained. The claim administrator, or any entity acting on behalf of the insurer, shall adopt the employee's social security number to replace the employee's DAN and to serve as the employee's permanent numerical identifier no later than 90 calendar days from the date the DAN was provided by the Division.~~prior to submitting the medical reportto the Division~~.

(8) An insurer, claim administrator or any entity acting on behalf of an insurer shall report to the Division the procedure code(s), number of line-items billed, amount paid including zero dollar payments, diagnosis code(s), modifier code(s), NDC number(s) and amount(s) charged, as billed by the health care provider when reporting these data to the Division. However, the insurer, claim administrator or any entity acting on behalf of an insurer may correct the procedure code(s) or modifier code(s) or NDC number(s) to effect payment and shall report both the provider billed code(s) and insurer adjusted code(s) pursuant to the MEIG. The insurer,

claim administrator or any entity acting on behalf of an insurer shall utilize the EOBR code "80" to notify the health care provider concerning any such billing errors and shall transmit EOBR code "80", in instances when the carrier corrects the provider coding, when reporting to the Division.

(9) An insurer, claim administrator or any entity acting on behalf of the insurer shall manually or electronically date stamp accurately completed Forms DFS-F5-DWC-9, DFS-F5-DWC-10 (or insurer pre-approved alternate form), DFS-F5-DWC-11, DFS-F5-DWC-90 or the electronic form equivalent on the "Date Insurer Received Bill" as defined in paragraph 69L-7.710(1)(o), F.A.C.

(10) When utilizing the option(s) available under paragraph 69L-7.750(8)(a), F.A.C., the insurer shall document the following:

(a) The option(s) selected; and,

(b) The specific effective date for each option selected; and,

(c) The insurer shall make this written documentation available to the Division for audit purposes pursuant to section 440.525, F.S. The insurer shall maintain written documentation from the "entity" acknowledging its responsibilities concerning "Date Insurer Received Bill" and "Date Insurer Paid Bill" for each option when the insurer selects options 2., 3., or 4. from paragraph 69L-7.750(8)(a), F.A.C., and shall also maintain written documentation identifying the applicability of the options selected in sufficient detail to allow verification of the coding of each medical bill under paragraph 69L-7.750(8)(c), F.A.C.

(11) An insurer, claim administrator or any entity acting on behalf of the insurer shall comply as indicated below to ensure the timely and correct reimbursement of properly completed medical bills:

(a) When adjudicating practitioner-dispensed medication bills, an insurer/claim administrator or any entity acting on behalf of an insurer shall use the Medi-Span Master Drug Database®, pursuant to paragraph 440.13(12)(c), F.S., to determine whether or not the dispensed medication is repackaged.

(b) When a medical bill is submitted for reimbursement by a health care provider, the insurer, claim administrator or entity acting on behalf of the insurer shall review the medical bill to determine if any of the criteria in paragraph 69L-7.740(11)(e), F.A.C., are present.

(c) If a medical bill is deficient according to the criteria listed in paragraph 69L-7.740(11)(g), F.A.C., and the applicable form completion instructions incorporated by reference in rule 69L-7.720, F.A.C., the insurer, claim administrator or entity acting on behalf of the insurer shall either:

1. Secure and/or correct the information on the medical bill and proceed to make a reimbursement decision to pay, adjust, disallow or deny billed charges within 45 days from the "Date Insurer Received Bill"; or

2. Return the medical bill to the provider within twenty-one (21) days of the "Date Insurer Received Bill" with a written statement identifying the deficiency criteria under which the medical bill is being returned. The written statement sent to the provider with the returned medical bill shall bear the following statement CAPITALIZED and in **BOLD** print: **"A HEALTH CARE PROVIDER MAY NOT BILL THE INJURED EMPLOYEE FOR SERVICES RENDERED FOR A COMPENSABLE WORK-RELATED INJURY."**

(d) If the insurer returns a medical bill to the provider pursuant to paragraph 69L-7.740(11)(g), F.A.C., the written statement, which shall accompany the returned bill shall include all deficiency criteria upon which the return of the medical bill are based.

(e) If the deficiency criteria upon which the return of the medical bill is based includes any of the deficiency criteria in subparagraphs 69L-7.740(11)(g)4.-7., F.A.C., and the applicable form completion instructions, the written statement shall identify the information that is illegible, incorrect, or omitted.

(f) An insurer may return a medical bill to a provider without issuance of an EOBR only on the basis of the deficiency criteria set forth in paragraph 69L-7.740(11)(e), F.A.C., and the applicable form completion instructions.

(g) The deficiency criteria upon which a medical bill is to be reviewed by the insurer, claim administrator or entity acting on behalf of the insurer for return to the provider pursuant to this sub-part of subsection 69L-7.740(11), F.A.C., are:

1. Services are billed on an incorrect medical billing form; or

2. The medical bill has been submitted to the incorrect insurer; or

3. The medical bill has been submitted to the incorrect claim administrator or entity acting on behalf of the insurer; or

4. Injured employee identification information required by this rule and the applicable form completion instructions is illegible on the medical bill; or

5. Injured employee identification information required by this rule and the applicable form completion instructions is incorrect on the medical bill; or

6. Billing information required by this rule and the applicable form completion instructions is illegible on the medical bill; or

7. Billing information required by this rule and the applicable form completion instructions is omitted or incomplete on the medical bill.

(h) An insurer, claim administrator or entity acting on behalf of the insurer shall establish and maintain a process by which medical bills that have been returned and written statements identifying the reason for return are compiled. The compiled information shall be sufficiently detailed to allow verification and review by the Division.

(12) A claim administrator or any entity acting on behalf of the insurer shall pay, adjust, disallow or deny billed charges within 45 days from the "Date Insurer Received Bill," pursuant to paragraph 440.20(2)(b), F.S.

(13) In completing an Explanation of Bill Review (EOBR), a claim administrator shall, for each line item billed, select the EOBR code(s) from the list below which identifies(y) the reason(s) for the reimbursement decision for each line item.

(a) The claim administrator may utilize up to three EOBR codes for each line item billed. When utilizing more than one EOBR code, the claim administrator shall list the EOBR codes that describe the basis for the claim administrator's reimbursement decision in descending order of importance. EOBR codes selected for a line item, that do not align with the actual payment, denial, disallowance, or adjustment made by the Insurer may be subject to pattern and practice penalties pursuant to s.440.525, F.S.

(b) The EOBR code list is as follows:

06 – Payment disallowed: location of service(s) is not appropriate for the level of service(s) billed.

10 – Payment denied: total denial: total compensability denied or the injury or illness for which service was rendered is not compensable. (Instructional note: A medical bill for a non-compensable injury or illness will have EOBR code 10 on all line items. EOBR code 10 is not a disallowance or adjustment code.)

11 – Payment denied: partial denial: diagnosis or procedure code for the line item service is not related to the compensable condition (Instructional note: insurer must specify the non-compensable diagnosis or procedure code on the EOBR~~condition~~).

21 – Payment disallowed: ~~medical necessity:~~ medical records reflect no physician's order was given for service rendered or supply provided.

22 – Payment disallowed: ~~medical necessity:~~ medical records reflect no physician's prescription was given for service rendered or supply provided.

(Instructional note: Line items containing services or procedure codes authorized by the Insurer may not use EOBR codes 23, 24, or 25)

23 – Payment disallowed: medical necessity: diagnosis does not support the service rendered (Instructional note: insurer shall provide supporting documentation to the health care provider with the EOBR).

24 – Payment disallowed: medical necessity: service rendered was not therapeutically appropriate rendered (Instructional note: insurer shall provide supporting documentation to the health care provider with the EOBR).

25 – Payment disallowed: medical necessity: service rendered was experimental, investigative or research in nature (Instructional note: insurer shall provide supporting documentation to the health care provider with the EOBR).

26 – Payment disallowed: service rendered by healthcare practitioner outside scope of practitioner's licensure.

30 – Payment disallowed: lack of authorization: no authorization given for service rendered or notice provided for emergency treatment pursuant to subsection 440.13(3), F.S.

(Instructional note: EOBR code 30 shall not be used to disallow drugs dispensed by an authorized treating physician.)

34 – Payment disallowed: no modification to the information provided on the medical bill. No payment made pursuant to contractual arrangement.

38 – Payment disallowed: insufficient documentation: documentation does not support this supply was dispensed to the patient.

39 – Payment disallowed: insufficient documentation: documentation does not support this medication was dispensed to the patient.

40 – Payment disallowed: insufficient documentation: documentation does not substantiate the service billed was rendered.

41 – Payment disallowed: insufficient documentation: level of evaluation and management service not supported by documentation. (Instructional note: Insurer shall specify missing components of evaluation and management code description on the EOBR.)

42 – Payment disallowed: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.

43 – Payment disallowed: insufficient documentation: frequency of service not supported by documentation.

44 – Payment disallowed: insufficient documentation: duration of service not supported by documentation.

45 – Payment disallowed: insufficient documentation: fraud statement not provided pursuant to subsection 440.105(7), F.S.

46 – Payment disallowed: insufficient documentation: required itemized statement not submitted with the medical bill.

47 – Payment disallowed: insufficient documentation: invoice or certification not submitted for implant.

48 – Payment disallowed: insufficient documentation: invoice not submitted for supplies.

49 – Payment disallowed: insufficient documentation: invoice not submitted for medication.

50 – Payment disallowed: insufficient documentation: specific documentation requested in writing at the time of authorization not submitted with the medical bill (insurers shall specify omitted documentation).

51 – Payment disallowed: insufficient documentation: required DFS-F5-DWC-25 not submitted.

52 – Payment disallowed: insufficient documentation: supply(ies) incidental to the procedure. (Instructional note: Incidental supply shall be specified on the EOBR.)

53 – Payment disallowed: insufficient documentation: required operative report not submitted with the medical bill.

54 – Payment disallowed: insufficient documentation: required narrative report not submitted with the medical bill.

58 – Payment disallowed: billing error: omitted or incorrect/invalid original manufacturer's NDC number.

NOTE: If a valid original manufacturer's NDC number for prescription medication is billed alone, it should be reimbursed and reported under EOBR code 98.

59 – Payment disallowed: billing error: omitted or incorrect/invalid repackaged NDC number.

NOTE: If a valid original manufacturer's NDC number for prescription medication is billed alone, it should be reimbursed and reported under EOBR code 98.

60 – Payment disallowed: billing error: line item service previously billed and reimbursement decision previously rendered.

NOTE: Use EOBR code 61 when all lines on bill are disallowed as duplicates. Do not transmit bill electronically to the Division.

61 – Payment disallowed: billing error: duplicate bill.

NOTE: Do not transmit bill electronically to the Division.

62 – Payment disallowed: billing error: incorrect procedure, modifier, units, supply code (Instructional note: insurer shall identify incorrect code on the EOBR).

63 – Payment disallowed: billing error: service billed is integral component of another procedure code. (Instructional note: insurer ~~S~~hall specify inclusive procedure code on the EOBR).

64 – Payment disallowed: billing error: service "not reimbursable" under applicable workers' compensation reimbursement manual.

65 – Payment disallowed: billing error: multiple providers billed on the same form.

66 – Payment disallowed: billing error: omitted procedure, modifier, units, or supply code.

67 – Payment disallowed: billing error: Same service billed multiple times on same date of service.

68 – Payment disallowed: billing error: Rental value has exceeded purchase price per written fee agreement.

71 – Payment adjusted: insufficient documentation: level of evaluation and management service not supported by documentation.

72 – Payment adjusted: insufficient documentation: intensity of physical medicine and rehabilitation service not supported by documentation.

73 – Payment adjusted: insufficient documentation: frequency of service not supported by documentation.

74 – Payment adjusted: insufficient documentation: duration of service not supported by documentation.

75 – Payment adjusted: insufficient documentation: specific documentation requested in writing at the time of authorization not submitted with the medical bill.

80 – Payment adjusted: billing error: correction of procedure, modifier, supply code, units, or Original Manufacturer's NDC Number (Instructional note: shall identify correction).

NOTE: Shall not be used with repackaged medications.

81 – Payment adjusted: billing error: payment modified pursuant to a charge audit.

83 – Payment adjusted: medical benefits paid apportioning out the percentage of the need for such care attributable to preexisting condition pursuant to paragraph 440.15(5)(b), F.S.

84 – Payment adjusted: co-payment applied pursuant to paragraph 440.13(13)(c), F.S.

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.

~~NOTE~~ Instructional note: EOBR Code 85 shall not be used in lieu of EOBR Code 93.

86 – Payment adjusted: billing error; repackaged medication; correction of NDC number dispensed or reimbursed pursuant to paragraph 440.13(12)(c), F.S. (insurer shall indicate the corrected NDC number dispensed or reimbursed).

90 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Health Care Provider Reimbursement Manual.

91 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers.

92 – Paid: no modification to the information provided on the medical bill: payment made pursuant to Florida Workers' Compensation Reimbursement Manual for Hospitals.

93 – Paid: no modification to the information provided on the medical bill: payment made pursuant to written contractual arrangement (network or PPO name required).

NOTE: EOBR Code 93 shall not be used in lieu of EOBR Code 85.

94 – Paid: Out-of-State Provider: payment made pursuant to the Out-of-State Provider section of the applicable Florida reimbursement manual.

95 – Paid: Reimbursement Dispute Resolution: payment made pursuant to receipt of a Determination or Final order on a Petition for Resolution of Reimbursement Dispute, pursuant to subsection 440.13(7), F.S.

96 – Paid: Payment made pursuant to a write-off by a health care provider self-insured employer.

97 – Paid: no modification to the information provided on the medical bill; repackaged medication; reimbursed at repackaged methodology pursuant to paragraph 440.13(12)(c), F.S.

98 – Paid: no modification to the information provided on the medical bill; dispensed medication; billed original manufacturer's NDC number only; reimbursed pursuant to paragraph 440.13(12)(c), F.S.

(14) A claim administrator or any entity acting on behalf of the insurer to pay, adjust, disallow or deny a filed bill shall send to the health care provider an EOBR detailing the adjudication of the submitted bill by line item, utilizing only the EOBR codes and code descriptors per line item, as set forth in subsection 69L-7.740(13), F.A.C., and shall include the insurer name, Division issued insurer code number, ~~and~~ corresponding insurer mailing address, and date the EOBR was issued. ~~However, a~~An insurer may choose to append an internal reason code to the EOBR it submits to the health care provider, when utilizing an EOBR code set forth in subsection 69L-7.740(13), F.A.C., that includes a code descriptor requiring the insurer to provide additional specification. A claim administrator or any entity acting on behalf of the insurer shall notify the health care provider of notice of payment or notice of adjustment, disallowance or denial only through an EOBR. An EOBR shall specifically state that the EOBR constitutes notice of disallowance or adjustment of payment within the meaning of subsection 440.13(7), F.S. An EOBR shall specifically identify the name and mailing address of the entity the carrier designates to receive service on behalf of the "carrier and all affected parties" for the purpose of receiving the petitioner's service of a copy of a petition for reimbursement dispute resolution by certified mail, pursuant to paragraph 440.13(7)(a), F.S. The requirements of this subpart do not apply to adjudication of a bill for pharmaceutical services provided by a pharmacist or pharmacy licensed under chapter 465, F.S., and billed on a Form DFS-F5-DWC-10 or its electronic equivalent, where, prior to the services being rendered, a binding contract exists between the claim administrator or any entity acting on behalf of the insurer, and the pharmacist or pharmacy or its representative that governs and specifies the amount to be paid by or on behalf of the insurer for the services.

(15) Copies of hospital medical records shall be subject to charges allowed pursuant to section 395.3025, F.S., and section 440.13, F.S.

(16) Failure by the insurer, claim administrator, or any entity acting on behalf of the insurer to meet its obligations may result in one or more of the following penalties in sections 440.13(7)(f) and 440.525, F.S., and Rule 69L-24.007, F.A.C.

Rulemaking Authority 440.13(4), 440.15(3)(b), (d), 440.185(5), 440.525(2), 440.591, 440.593(5) FS. Law Implemented 440.09, 440.13(2)(a), (3), (4), (6), (11), (12), (14), (16), 440.15(3)(b), (d), (5), 440.185(5), (9), 440.20(6), 440.525(2), 440.593 FS. History–New 2-18-16. Editorial Note: Formerly 69L-7.710(5).