

**FLORIDA WORKERS' COMPENSATION
REIMBURSEMENT MANUAL FOR HOSPITALS
2005 Edition**

Rule Chapter 69L-7.501, Florida Administrative Code

69L-7.501 Florida Workers' Compensation Reimbursement Manual for Hospitals.

(1) The Florida Workers' Compensation Reimbursement Manual for Hospitals, 2005 Edition, is adopted by reference as part of this rule. The manual contains reimbursement policies and per diem rates for hospital services and supplies.

(2) Form DFS-F5-DWC-90, (UB-92 HCFA-1450 Uniform Bill, rev. 1992), is hereby incorporated by reference as part of this rule. In addition, the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition is incorporated by reference as part of this rule. The manual contains reimbursement policies, guidelines, codes and maximum reimbursement allowances for physical therapy, occupational therapy, speech therapy, radiology and clinical laboratory services which shall be applied to hospital services provided on an outpatient basis only.

(3) The Florida Workers' Compensation Reimbursement Manual for Hospitals, 2005 Edition and Form DFS-F5-DWC-90, incorporated above, are available for inspection during normal business hours at the State of Florida Department of Financial Services, Document Processing Section, 200 East Gaines Street, Tallahassee, Florida 32399-0311, or via the Department's website at <http://www.fldfs.com>.

Specific Authority 440.13(14), 440.591 FS. Law Implemented 440.13(7), (12), (14) FS. History—New 6-9-87, Amended 6-1-92, 10-27-99, 7-3-01, Formerly 38F-7.501, 4L-7.501, Amended 12-4-03, 1-1-04, 7-4-04,_____.

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Section 1: Managed Care.

Under Florida's program, an authorized workers' compensation managed care arrangement and a hospital may enter into various types of written agreements directly or indirectly with insurers to provide and to manage medically necessary remedial treatment, care and attendance to injured employees for an agreed upon contract price. The terms of an agreement may follow the specific requirements of this manual or may contain additional or different requirements.

Section 2: Publications Adopted by Reference.

The standards in the following publications are adopted by reference (see Appendix B for ordering information):

1. Length of Stay by Operation, United States, 2003.
2. Length of Stay by Diagnosis, United States, 2003.
3. Florida's Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition, Sections VIII and XI, General Instructions, Part A, Part C and Appendix D.

Section 3: Billing.

The hospital and insurer shall utilize the Division's Medical Services Billing, Filing, and Reporting Rule (Rule Chapter 69L-7.602, Florida Administrative Code) to determine the hospital billing form, special billing or reporting instructions, and its responsibility for reviewing and requesting documentation to comply with s. 440.20(2)(b), F.S. (See Appendix B to obtain rule.)

Section 4: Authorization.

- A. All requirements of this manual apply to hospital services provided to an injured employee within the state of Florida, outside of the state of Florida and in any federal facility.
- B. Hospital emergency services and care, defined in 395.002, F.S., do not require authorization at the time they are rendered. However, once it is determined that an emergency medical condition, defined in 395.002, F.S. does not exist or that the care, treatment, or surgery rendered in the hospital has relieved or eliminated the emergency medical condition, any related follow-up care or treatment or referral to an appropriate, less costly provider, must be expressly authorized by the carrier prior to the provision of the additional treatment or care. When the emergency medical condition or the care results in an emergency hospital admission of the injured employee, the hospital must notify the insurer within 24 hours by telephone.
- C. A hospital shall obtain authorization from the insurer prior to providing non-emergency outpatient services or the inpatient admission of an employee for a work-related injury.

- D. A hospital shall obtain authorization from the insurer and shall record the authorization in the injured employee's medical record or billing or financial record including the date on which authorization was requested and received. Also, the hospital shall include the name and title of the insurer's designee authorizing the hospital services and the length of stay precertified as required below.
- E. The hospital shall inform the insurer of any non-compensable conditions for which the injured employee will receive therapeutic or diagnostic services during the course of hospitalization and include the name and address of the responsible party for the non-compensable services.

Section 5 : Precertification and Length of Stay.

- A. When authorizing inpatient admissions, the insurer shall precertify the number of days of hospitalization for which reimbursement can be anticipated according to national length of stay standards incorporated by reference in Section 2 of this manual.
- B. When it is evident at the time of admission or during the stay that the precertified days will be exceeded, the hospital must inform the insurer and provide the opportunity for the insurer to approve additional reimbursement for medically necessary care in order to avoid unnecessary reimbursement and utilization disputes resulting from overpayments or underpayments.

Section 6: Hospital Release of Information Form.

- A. The hospital shall obtain a signed release of information form from each patient upon admission that meets the requirements of Chapter 395, Florida Statutes (F.S.).
- B. When the patient's condition at the time of the admission prevents compliance with this requirement, the form should be signed by the patient or guardian, curator, or personal representative as soon as circumstances permit.
- C. If the patient refuses to sign the release of information form, the hospital must notify the insurer immediately. When this is not possible, the hospital must notify the insurer by close of business on the next regular business day.
- D. The patient's record must include either the signed release of information form or the documentation of refusal to sign the form and the notification to the insurer of the refusal.
- E. Specific records cannot be disclosed without consent of the person to whom they pertain. These records include:

1. Mental health records (s. 394.4615, F.S.);
2. Records of substance abuse impaired persons (s. 397.501, F.S.);
3. The identity and test results of persons upon whom a test for human immunodeficiency virus has been made (s.381.004(3), F.S.).

Section 7: Medical Records.

The hospital shall maintain medical records according to Chapter 395, F.S. and Rule Chapter 59A-3.270, Florida Administrative Code (F.A.C.) establishing criteria for problem-oriented medical record systems in hospitals. (See Appendix B to obtain rule.)

Section 8: Copying Charges for Medical Records

- A. Pursuant to section 440.13(4)(b), F.S., when a hospital provides copies of medical records to the injured employee or injured employee's attorney, the hospital may charge the injured employee or the injured employee's attorney \$.50 per page for paper medical records copied and the actual direct cost of copying x-rays, microfilm, or other non-paper medical records. No other copy charges or search charges may be charged to the injured employee as part of the services provided to the injured employee by the hospital.
- B. Pursuant to section 395.3025, F.S., when a hospital provides copies to the employer or insurer or its attorney upon written request, the hospital may charge the following:
 1. \$1.00 per page for paper medical record.
 2. \$2.00 per fiche (microfiche) and other non-paper medical records.
 - a. Actual sales tax and postage for mailing the copies, and
 - b. An additional fee of \$1.00 per year for each year of copies of medical records requested, but no additional search or retrieval fee.
- C. The above charges for copies of medical records apply to each hospital and to any copy services providing copies to the insurer on behalf of the hospital.
- D. No charges shall be reimbursed for copies of the injured employee's medical record provided to the Division or the Agency for Health Care Administration.
- E. When the insurer requires that the hospital medical records must accompany the bill in order for payment to be made, the insurer shall reimburse the hospital for the copy of the medical records according to B above.

Section 9: Out of State Hospital Services.

- A. Hospital services provided by an out-of-state hospital require authorization from the insurer.
- B. A hospital outside of the state of Florida shall be reimbursed at either:
 - 1. The amount agreed upon by the hospital and the insurer during authorization, **whether for inpatient or outpatient services.**
 - 2. When no amount is pre-approved, **the hospital shall receive the following:**
 - a. the greater of the reimbursement established for inpatient services under Florida's Workers' Compensation law or rules or the maximum payment amount provided under the workers' compensation statute of the jurisdiction in which the hospital is located and**
 - b. the greater of the reimbursement percentages established for outpatient services, except as delineated for radiology, clinical laboratory, physical therapy, occupational therapy and speech therapy in Section XI, Part A of the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition, or the maximum payment amount provided under the workers' compensation statute of the jurisdiction in which the hospital is located.**

Section 10: Federal Facilities.

- A. Treatment provided in federal facilities requires authorization from the insurer.
- B. All requirements of this manual apply to hospital services supplied to an injured employee in a federal hospital except that federal facilities:
 - 1. Bill on their own billing form.
 - 2. Are not subject to the reimbursement limitations of this rule.

Section 11: Reimbursement.

- A. General.
 - 1. The insurer shall not reimburse charges for non-compensable services and care when they are provided concurrently with inpatient or outpatient hospital services for a compensable injury. All charges for the non-compensable care and services shall be the responsibility of the patient.

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2. The insurer, in the case of either authorized outpatient services and care or an authorized inpatient admission that exceeds the stop loss point as defined in this rule, shall disallow reimbursement for a specifically itemized charge on the itemized statement that does not appear to be:
 - a. consistent with the hospital's Charge Master or billing protocol
 - b. medically necessary for the authorized care and services relating to the compensable injury or
 - c. consistent with documented services in the medical record.
3. Notwithstanding the insurer's right to disallow charges under the preceding circumstances, the insurer is not exempt from complying with the provisions of s. 440.20(2)(b), F.S., that require timely payment, adjustment, disallowance or denial of a hospital bill, contingent upon resolution of issues relating to medical necessity (overutilization), utilization control or billing error.
4. Within 30 days after a request from either party, the hospital shall make available at its administrative office, its Charge Master and the patient's medical record to verify the accuracy of an injured employee's bill. The hospital shall not charge for making the information available for a medical record review except when providing copies of medical records as allowed in Section 8 of this manual.
5. The insurer shall not reimburse a hospital for physician services billed by the hospital on the Form DFS-F5-DWC-90, (UB-92 HCFA-1450 Uniform Bill, rev. 1992). For proper billing and reimbursement of physician services rendered in any location, refer to Appendix B, Resource Documents for Rule Chapter 69L-7.602, F.A.C. and Rule Chapter 69L-7.020, F.A.C.

B. Inpatient Charges.

1. Acute care hospitals and trauma centers shall be reimbursed on a per diem basis as follows:
 - a. Inpatient services provided by an acute care hospital:
 - (1) Surgical stay: \$3,213.73
 - (2) Non-surgical stay: \$1,906.89
 - b. Inpatient services provided by a trauma center:
 - (1) Surgical stay: \$3,214.66
 - (2) Non-surgical stay: \$1,931.96

2. Except when Form Locator 22 contains discharge code 20, the insurer shall not exceed the maximum reimbursement allowance for a single per diem when a discharge occurs within 24 hours of admission to a hospital facility.
3. The insurer shall not reimburse per diem for the day of discharge from a hospital.
4. The insurer shall not disallow any portion of the length of stay for an authorized inpatient admission except when documentation in the medical record does not support the medical necessity for the number of precertified days or when the length of stay exceeds the precertified days authorized by the insurer at the time of authorization.
5. When total gross charges for inpatient services exceed \$50,000.00, the insurer shall use the stop-loss method to reimburse the hospital instead of the established per diem.
 - a. In determining the total gross charges, the charges for surgical implant devices, prosthetics and orthotics shall be based on an amount not to exceed twenty (20) percent above invoice cost, including applicable manufacturer's shipping and handling.
 - b. Reimbursement shall be at 75 percent of charges for documented, medically necessary services except for surgical implant devices, prosthetics and orthotics, for which reimbursement shall be limited to an amount not to exceed twenty (20) percent above invoice cost, including applicable manufacturer's shipping and handling. (See Appendix C for calculation example.)
 - c. Disallowed charges for undocumented or medically unnecessary services shall be determined according to paragraph A of this section.
6. Inpatient services provided at a rehabilitation hospital or a psychiatric hospital for a compensable injury shall be reimbursed at 75 percent of charges for medically necessary services, excluding surgical implant devices, prosthetics and orthotics. Surgical implant devices, prosthetics and orthotics shall be reimbursed at an amount not to exceed twenty (20) percent above invoice cost, including applicable manufacturer's shipping and handling.

C. Outpatient Charges.

1. All compensable services for hospital outpatient care shall be reimbursed at 75 percent of the hospital's usual and customary charges for medically necessary services and care with the following exceptions:

- a. Scheduled outpatient surgeries shall be reimbursed at 60 percent of the hospital's total outpatient charges on the DFS-F5-DWC-90, excluding surgical implant devices, prosthetics and orthotics or unless the services are specifically disallowed from reimbursement by this manual.
 - (1.) An insurer shall reimburse the hospital for surgical implant devices, prosthetics and orthotics at an amount not to exceed twenty (20) percent above invoice cost, including applicable manufacturer's shipping and handling. (See Appendix C for calculation example.)
 - (2.) For the purpose of identifying hospital bills subject to the outpatient surgery reimbursement provisions, insurers shall verify that a procedure code in Form Locator 44 is a valid CPT code from among the surgery procedures listed within the 10021 through 69990 range.
 - (3.) An insurer shall reimburse the hospital based on inpatient charges, rather than at 60 percent of total charges when a scheduled outpatient surgery necessitates an inpatient admission within 23 hours of the procedure. The reimbursement shall be according to the allowances in subsection B above for each medically necessary day of admission not to exceed the median length of stay in the standards incorporated by reference in Section 2 of this manual.
 - (4.) An insurer shall reimburse the hospital any additional amount for medically necessary services and care beyond the median length of stay subject to other reimbursement guidelines in subsection B above.
- b. Scheduled non-emergency medically necessary radiology and clinical laboratory services not provided in conjunction with surgical care in item a. above, shall be reimbursed according to the schedule of maximum reimbursement allowances (MRAs) which applies to non-hospital providers in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition, Section XI, General Instructions Part C, incorporated pursuant to Rule Chapter 69L-7.020, Florida Administrative Code (F.A.C.). (Section XI, General Instructions, of the provider manual provides information on determining locality payment amounts in Part C.)
 - (1.) Insurers shall adjust only clinical laboratory and radiology outpatient services identified in Form Locator 42 of the DFS-F5-DWC-90 billed under the following revenue codes: 0300-0309, 0320-0329, 0330-0339, 0340-0349, 0350-0359, 0400-0409, and 0610-0619.
 - (2.) Insurers shall determine the non-hospital provider facility MRA in Section XI, Part C that applies for the technical component of the CPT or HCPCS code, reported by the hospital in Form Locator 44 of the DFS-F5-DWC-90.

- (3) Insurers shall determine the number of units of service reported in Form Locator 46 of the DFS-F5-DWC-90 by the hospital for each CPT or HCPCS code.
 - (4) Insurers shall multiply the **facility** MRA determined in item (2) above by the units of service to determine the outpatient hospital maximum reimbursement allowance for the specific radiology or clinical laboratory services.
 - (5) For the purpose of applying the non-hospital provider **facility** MRAs, clinical laboratory and radiology services provided by the hospital more than 48 hours prior to an outpatient surgery shall be considered scheduled non-emergency services not provided in conjunction with surgical care and shall be paid according to the non-hospital provider MRAs.
- c. All medically necessary physical, occupational, and speech therapy services shall also be adjusted to the schedule of MRAs which applies to non-hospital providers in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition, Section XI, General **Instructions** Part **C** and Appendix D incorporated pursuant to Rule Chapter 69L-7.020, Florida Administrative Code (F.A.C.). (**Section XI, General Instructions, of the provider manual provides information on determining locality payment amounts in Part C.**)
- (1) Insurers shall adjust only outpatient physical therapy, occupational therapy, and speech therapy services identified in Form Locator 42 of the DFS-F5-DWC-90 billed under the following revenue codes: 0420-0429, 0430-0439, 0440-0449, 0930-0932.
 - (2) Insurers shall determine the non-hospital provider **facility** MRA that applies based on the workers' compensation unique code, the CPT code or the HCPCS code reported by the hospital in Form Locator 44 of the DFS-F5-DWC-90.
 - (3) Insurers shall determine the number of units of physical therapy, occupational therapy, or speech therapy services reported by the hospital for each procedure code in Form Locator 46 of the DFS-F5-DWC-90.
 - (4) Insurers shall multiply the **facility** MRA in Section XI, **Part C**, by the units of service to determine the outpatient hospital maximum reimbursement allowance for the specific physical, occupational or speech therapy services.
 - (5) Provisions of Section VIII, Physical Medicine and Rehabilitation Services, of the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition shall also apply to outpatient

therapy reimbursement and are hereby incorporated pursuant to Rule Chapter 69L-7.020, F.A.C.

- d. Medically necessary surgical implant devices, prosthetics and orthotics required in the course of outpatient services, whether for scheduled or emergency care, shall not exceed twenty (20) percent above the invoice cost to the hospital, including applicable manufacturer's shipping and handling.
2. Insurers shall apply non-emergency reimbursement provisions to only those bills that do not report revenue codes 0450-0459 in Form Locator 42 or when the insurer determines that revenue codes 0450-0459 are billed for services that do not meet the definition of emergency services and care pursuant to chapter 395, F.S..
3. Insurers shall not reimburse for revenue codes 0450-0459 in Form Locator 42 when the primary purpose of the emergency room utilization is routine follow-up of prior hospital emergency services and care subject to Section 4 of this manual.
4. Insurers shall not reimburse more than 23 hours for an admission to an outpatient observation unit reported under revenue codes 0762 and 0769 in Form Locator 42 of the DFS-F5-DWC-90.

Section 12: Surgical Implant Devices, Prosthetics and Orthotics.

Insurers shall reimburse surgical implant devices, prosthetics and orthotics under revenue codes 0274, 0275, 0276 and 0278. Reimbursement shall include hardware and instrumentation and shall not exceed twenty (20) percent above the invoice cost to the hospital, including applicable manufacturer's shipping and handling. (See Appendix C for calculation example.)

Section 13: Reimbursement and Utilization Disputes.

Any party contesting the disallowance or adjustment of payment by the carrier shall petition the Agency for Health Care Administration pursuant to the requirements of s. 440.13(7), F.S. and Rule Chapter 59A-31.002, F.A.C. (See Appendix B to obtain rule.)

APPENDIX A
DEFINITIONS

Appendix A: Definitions.

- (1) **“Admission”** means an injured employee is admitted to a hospital for inpatient services when, based on the admission order from the treating physician, the injured employee will require an overnight stay for medical care
- (2) **“Agency”** means the Agency for Health Care Administration as it is defined in s. 440.02(3), F.S.
- (3) **“Authorization”** means the approval given to a hospital or federal facility by the insurer or designated party for the provision of medical services to an injured employee who has had a compensable injury
- (4) **“Charge”** means the dollar amount billed
- (5) **“Charge Master”** means a comprehensive coded list developed by a hospital representing usual charges for specific services
- (6) **“Current Procedural Terminology” (CPT)** means the American Medical Association (AMA) reference document containing descriptive terms to identify codes for reporting medical procedures and services. CPT codes may also be referred to as HCPCS Level I codes.
- (7) **“Division”** means the Division of Workers' Compensation of the Department of Financial Services as defined in s.440.02(14), F.S.
- (8) **“DFS-F5-DWC-90”** means the current hospital billing form, (UB-92 HCFA-1450 Uniform Bill, rev. 1992) pursuant to s. 627.647, F.S. The form is also known as the HCFA 1450, Uniform Bill.
- (9) **“HCPCS (Healthcare Common Procedure Coding System) National Level II Codes” (HCPCS)** means the Center for Medicare and Medicaid Services (CMS) reference document listing descriptive codes for reporting professional services, procedures, and supplies provided by health care providers.
- (10) **“Health Care Provider”** means a provider as defined in s.440.13, F.S.
- (11) **“Hospital”** means a health care facility as defined in Chapter 395, F.S.
- (12) **“Insurer”** means any entity as defined in s. 440.02, F.S.
- (13) **“Itemized Statement”** means a detailed listing of hospital provided services and supplies, including the quantity and charges for each service or supply.
- (14) **“Length of Stay Standards”** means the Length of Stay by Operation, United States, 2003 and the Length of Stay by Diagnosis, 2003 adopted by reference in Section 2 of this manual.

- (15) **“Medical Record”** means the patient records maintained in accordance with form and content required under Chapter 395, F.S. and Chapter 59A-3.270, F.A.C.
- (16) **“Medical Record Review”** means a review of the medical record of the injured employee’s hospital stay in order to verify the medical necessity of the services and care as they relate to the itemized statement for a specific DFS-F5-DWC-90.
- (17) **“Medically Necessary and Medical Necessity”** means any medical service or medical supply which meets the definition of the terms according to s.440.13(1)(l),F.S.
- (18) **“Per Diem”** means a reimbursement allowance based on a fixed rate per day which is inclusive of all services rather than on a charge by charge basis.
- (19) **“Physician”** means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractor licensed under chapter 460, a podiatrist licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, each of whom must be certified by the agency as a health care provider (s. 440.13 (1) (q), F.S.).
- (20) **“Stop-Loss Method or Stop-Loss Point”** means an independent reimbursement methodology used in place of and not in addition to per diem reimbursement for an inpatient admission to an acute care hospital or a trauma center for which the total gross charges exceed \$50,000. The methodology applies when total gross charges reach the \$50,000.00 threshold and allows reimbursement of 75 percent of the hospital’s charges for only medically necessary services, except for surgical implant devices, orthotics, and prosthetics.
- (21) **“Surgical Stay”** means an admission for which the primary purpose is to render surgical services that by their nature require the use of the hospital operative suite and recovery room for the perioperative care of the patient. Certain exceptions shall also be considered surgical stays including an emergency condition that requires immediate surgical intervention in an alternate setting such as in an emergency room or an intensive care unit.

**APPENDIX B
RESOURCE DOCUMENTS**

Appendix B: Resource Documents

1. Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2005 Edition, Department of Financial Services Document Processing Section, 200 East Gaines Street, Tallahassee, Florida 32399-0311. Obtain the manual free of charge online at <http://www.fldfs.com/wc> under Publications or purchase in hardcopy according to the Manual Purchase Instructions on the Document Order Form at the same site.
2. Length of Stay by Operation, United States, 2003. Solucient, 1800 Sherman Avenue, Evanston, Illinois 60201. Order online at <http://www.solucient.com/> or toll free at (800) 568-3282.
3. Length of Stay by Diagnosis, United States, 2003. Solucient, 1800 Sherman Avenue, Evanston, Illinois 60201. Order online at <http://www.solucient.com/> or toll free at (800) 568-3282.
4. Rule Chapter 59A-3.270, Florida Administrative Code, Health Information Management Rule. Obtain the rule free of charge online at <http://fac.dos.state.fl.us/faconline/Chapter59.pdf>.
5. Rule Chapter 59A-31.002, Florida Administrative Code, Disputed Reimbursement Rule. Obtain the rule free of charge online at <http://fac.dos.state.fl.us/faconline/Chapter59.pdf>.
6. Rule Chapter 69L-7.602, Florida Administrative Code, Workers' Compensation Medical Services Billing, Filing, and Reporting Rule. Obtain the rule free of charge online at <http://www.fldfs.com/wc> under Rules and Forms
7. UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, updated December 2004, (UB-92 Manual). Florida Hospital Association, Post Office Box 531107, Orlando, Florida 32853-1107. Telephone: (407) 422-5948.
8. List of State Approved Trauma Centers. Obtain free of charge online at <http://www.doh.state.fl.us/ems/Trauma/verification.html>.

APPENDIX C

CALCULATION EXAMPLE

Appendix C: Calculation Example for Total Gross Charges Involving Surgical Implant Devices, Prosthetics and Orthotics

A. Inpatient Charges

		Method of Reimbursement	Reimbursement
Insurer Calculation Example #1			
Hospital Charges excluding Implants	\$ 45,000		
Implant cost plus 20%	\$ 4,000		
Total Gross Charges	\$ 49,000	Pay Per Diem	
Amount Due			Per Diem * Days
Insurer Calculation Example #2			
Hospital Charges excluding Implants	\$ 45,000	Pay at 75%	\$ 33,750
Implant cost plus 20%	\$ 6,000	Pay at Cost Plus 20%	\$ 6,000
Total Gross Charges	\$ 51,000		
Amount Due			\$ 39,750

B. Outpatient Charges:

		Method of Reimbursement	Reimbursement
Insurer Calculation Example #1			
Hospital Charges excluding Implants	\$ 45,000	Pay at 60%	\$ 27,000
Implant cost plus 20%	\$ 4,000	Pay at Cost Plus 20%	\$ 4,000
Total Gross Charges	\$ 49,000		
Amount Due			\$ 31,000

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