

Florida Workers' Compensation

Reimbursement Manual for Hospitals

Rule 69L-7.501, F.A.C.

2009 Edition



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Chapter 1 Introduction and Overview

Introduction

Changes to the Manual will be sent out as electronic updates via the Division of Workers' Compensation E-Alert system. An update can be a change, addition, or correction to the guidelines. Updates will be available under 'Publications' immediately proximal to the affected Manual on the DWC web site.

It is important that the health care providers and the insurers read the updated material and file it in the Manual. Both parties have a responsibility for certain duties when filing or paying workers' compensation claims for injured employees.

e-Alert System

The Division has an electronic alert system to notify subscribers of changes in guidelines, upcoming news impacting the Workers' Compensation industry, dates of public meetings and workshops. To subscribe to the e-Alerts, please go to the [DWC web site](#). Look for the box entitled DWC e-Alert on the right side. Once completed, you shall receive e-Alerts whenever they are provided by the Division.

Explanation of the Update Log

The health care provider and insurer can use the update log to determine if all the updates to the Manual have been received.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

1. File new Chapters or replacement pages
2. File the new update log

UPDATE NO.	EFFECTIVE DATE

Chapter 1 Introduction and Overview, continued

Overview

Introduction

This Chapter introduces the format used for the Florida Workers' Compensation Reimbursement Manual for Hospitals and tells the reader how to use the Manual.

Background

There are 3 different Workers' Compensation Reimbursement Manuals:

- Florida Workers' Compensation Reimbursement Manual for Hospitals, Rule 69L-7.501, F.A.C.
 - Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100 F.A.C., and
 - Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C.
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Other Applicable Rules

In addition to this Manual, the Florida Workers' Compensation Reimbursement Manual for Hospitals, Rule 69L-7.501, F.A.C., also recognizes the following resources:

1. The Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, 69L-7.602, F.A.C.
 2. The Florida Workers' Compensation Health Care Provider Reimbursement Manual, incorporated by reference into Rule 69L-7.020, F.A.C.
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Legal Authority

The following Statute and Chapter Rule govern Workers' Compensation billing, filing and reporting in Florida:

- Chapter 440, Florida Statutes (F.S.)
- Chapter 69L-7, Florida Administrative Code (F.A.C.)

The specific Florida Statutes and Florida Administrative Code for each service are cited for reference in each specific Manual where appropriate.

Chapter 1 Introduction and Overview, continued

Manual Use and Format

Purpose

The purpose of the Florida Workers' Compensation Reimbursement Manual for Hospitals is to furnish providers with the guidelines and procedures needed to submit medical bills to insurers or self-insured employers for services provided in a hospital setting to injured workers and to ensure that insurers receive adequate billing information to make accurate, appropriate payment for services rendered.

This Manual provides descriptions and instructions on how and when to complete forms and other documents that will assist in the bill submission process.

Characteristics of the Manual

Format

The format styles used in the Manuals represent a concise and consistent way of displaying complex, technical material.

Information Block

Information Blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of a subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note:

Note: is used most frequently to refer the user to pertinent material located elsewhere in the Manual, related Rules, specific statutory authority or to exceptions and limitations to a guideline.

Chapter 1 Introduction and Overview, continued

Manual Updates

Update Log

The first page of each Manual will contain an update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current Manual have been received.

Each update will be designated by an "Update No." and the "Effective Date".

How Changes Are Updated

The Manual will be updated as needed. When a Manual is updated, the resulting new Manual will be replaced with a new effective date throughout at the bottom of each page.

Identifying New Material

New material will be identified by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left and right of the label and the information block.

New Material in an Existing Information Block

A paragraph within an existing information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

A paragraph with new material will be indicated in this manner.

Chapter 2 Program Requirements

Introduction and Purpose of Manual

The Florida Workers' Compensation Reimbursement Manual for Hospitals contains the Maximum Reimbursement Allowances (MRA) determined by the Three Member Panel¹ and establishes policy, procedures, principles and standards for implementing statutory provisions regarding reimbursement for medically necessary services and supplies provided to injured workers in a hospital setting. The policy, procedures, principles and standards in this Manual are in addition to the requirements established by the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule.²

This Manual can be obtained free of charge on the [DWC web site](#), or purchased in hard copy from the Department of Financial Services, Document Processing Section, at 200 East Gaines Street, Tallahassee, Florida 32399-0311.

Unless otherwise specified in this Manual, the terms "insurer" and "carrier" are used interchangeably and have the same meanings as defined at s. 440.02, F.S., and may also refer to a service company, third party administrator (TPA) or other entity acting on behalf of an insurer for the purposes of administering workers' compensation benefits for its insured(s). The insurer shall be held accountable for all actions taken by a service company, TPA, or other entity acting on its behalf when adjusting, reimbursing, disallowing or denying reimbursement to hospitals.

¹ Section 440.13(12), Florida Statutes

² Chapter 69L-7.602, Florida Administrative Code

Chapter 2 Program Requirements, continued

Fraud Statement	<p>All health care providers shall provide his or her personal signature, at least annually to the insurer, attesting that he or she has reviewed, understands, and acknowledges the following statement:</p> <p>“Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, F.S.”</p>
Billing	<p>Hospitals and insurers shall comply with the requirements of the Workers' Compensation Medical Services Billing, Filing, and Reporting Rule 69L-7.602, F.A.C.</p> <p>Additional billing, reporting and documentation requirements specific to requesting reimbursement for surgical implants when used in an inpatient hospital setting are set forth in Chapter 5 of this Manual.</p>
Hospital Responsibilities	<p>Hospitals shall provide to the insurer additional form completion requirements or supporting documentation beyond those required in Rule 69L-7.602, F.A.C., which the insurer may require for a reimbursement determination, when the insurer informs the hospital in writing at the time hospital services are authorized.</p>
Insurer Responsibilities	<p>Insurers shall inform in-state and out-of-state hospitals of the specific reporting, billing and submission requirements of Rule 69L-7.602, F.A.C., and provide the specific address for submitting the hospital bill.</p>

Chapter 3 Utilization Control

Authorization of Non-Emergency Services and Care

A hospital shall obtain authorization from the insurer prior to providing any non-emergency medical treatment, care or attendance for a patient's work-related injury or condition.

A hospital shall record the authorization in the injured employee's medical record or in the hospital's billing or financial records(s).

A hospital's recorded authorization shall include the following:

- The date(s) on which authorization was requested and received;
- The name of the insurer or its designated entity, and the person authorizing the hospital services.³

Emergency Services and Care

Emergency services and care, defined in s. 395.002, F.S., do not require authorization at the time they are rendered. A hospital that renders emergency care must notify the insurer by the close of the third business day after it has rendered such care. However, when an emergency medical condition requires or results in an emergency hospital admission, the hospital shall notify the insurer by telephone within 24 hours of the admission.⁴

When it is determined that an emergency medical condition, defined in s. 395.002, F.S., does not exist or no longer exists and only non-emergent follow-up examination or services are required or recommended, any related follow-up care or treatment or referral must be expressly authorized by the insurer prior to the provision of the additional treatment or care.⁵

³ See Pre-Certification of Length of Stay for additional authorization requirements for inpatient care.

⁴ Subsection 440.13(3)(b), Florida Statutes.

⁵ Subsection 440.13(3)(c), Florida Statutes.

Chapter 3 Utilization Control, continued

Pre-certification of Length of Stay

When authorizing inpatient admissions, the insurer shall pre-certify the number of hospitalization days for which reimbursement can be anticipated, according to an authoritative resource for length of stay data, such as *Length of Stay (LOS) by Diagnosis and Operation*, United States, published and copyrighted by Solucient, LLC, and recommended by the Division of Workers' Compensation for use by hospitals and insurers. Solucient's *LOS Manuals* may be obtained from Solucient, LLC, 1007 Church Street, Suite 700, Evanston, Illinois 60201 or (800) 568-3282.

Irrespective of the estimated length of stay pre-certified by the insurer, reimbursement for hospital services shall be based on the documentation of the medical necessity of the hospital services rendered as reflected in the medical record.

Medical record reviews to determine the medical necessity of hospital services may be performed either concurrently during the hospital stay, or retrospectively after discharge.

Note: A retrospective medical record review shall not toll the 45 day time period established to pay, disallow or deny the hospital bill.⁶

⁶ Subsection 440.20(2)(b), Florida Statutes.

Chapter 4 Medical Record Release and Copy Charges

Medical Record

Hospitals shall create and maintain medical records of all workers' compensation claimants in accordance with the form and content required by s. 395.3015, F.S., and Rule 59A-3.270, F.A.C., and may not release any identifying medical record(s) or protected health information (PHI) except as allowed or required by law.

Mandatory Disclosure

Unless otherwise prohibited by law, and subject to the confidentiality requirements of state and federal law(s), upon request of the Division, Office of Judges of Compensation Claims, employee, employer or insurer, hospitals shall produce any and all medical records, reports, and information of an injured employee relevant to the particular injury or illness for which compensability has been accepted or for which it is necessary to determine compensability.⁷

Copying Charges for Medical Records

An injured employee or injured employee's attorney requesting copies of medical records shall reimburse the hospital for copying charges according to s. 440.13(4)(b), F.S., and Rule 69L-7.601, F.A.C., and the hospital may charge no more than 50 cents per page for copying the records and the hospital's actual direct costs for X rays, microfilm, or other non-paper records.

No other copy charges or search charges may be charged to the injured employee or the injured employee's attorney as part of the services provided to the injured employee by the hospital.

An insurer, employer or authorized representative requesting copies of medical records shall reimburse the hospital for copying charges according to [s. 395.3025, F.S.](#)

⁷ Subsection 440.13(4)(c), Florida Statutes

Chapter 4 Medical Record Release and Copy Charges, continued

Limits on Copying Charges

The limits on charges apply regardless of whether the retrieval and copying are performed in-house or contracted out for completion by a copy service or other medical record maintenance service, and also apply when the insurer requires hospital medical records submission with a bill in order for payment to be made or for the purpose of an audit or review conducted under Chapter 9 of this Manual.

The above charges apply to all copies of original documents requested by an insurer whether the request for the copies is made before services are rendered or after services are rendered.

The above charges apply to all copies of original documents requested by an insurer whether the copies of documents are sent to the insurer for the purpose of performing an in-house desk audit or review in lieu of an on-site audit or review at the hospital, or whether the request is made in the course of an on-site audit or medical record review, and whether the request for copies is for an entire document or for selected portion(s) of a document.

Hospitals shall not charge any fee when required by law or Rule to produce any original medical, financial, or charge records for on-site audit or inspection by an insurer.

Hospitals shall not be reimbursed any charges for copies of medical records required by the Division or by the Office of Judges of Compensation Claims in performance of their statutory duties implementing and enforcing the Workers' Compensation Law.

Chapter 5 Inpatient Reimbursement Schedules

Reported Charges

Except as otherwise provided in this Manual, charges for hospital inpatient services shall be reimbursed according to the Per Diem Fee Schedule provided in this Chapter or according to a clearly defined, mutually agreed upon contract reimbursement agreement between the hospital and the insurer. The length of hospital stay shall be pre-certified according to the provisions in Chapter 3 of this Manual.

Note: See **Pre-Certification of Length of Stay** in Chapter 3.

Determining Surgical Stay or Non-Surgical Stay

Determination of whether inpatient services are surgical or non-surgical shall be based on the CMS-defined operative status for the ICD-9-CM primary procedure code reported by the hospital in the appropriate Form Locator on the hospital billing form in accordance with Rule 69L-7.602, F.A.C.

The CMS-defined operative status of ICD-9-CM primary procedure codes shall be determined by reference to an authoritative resource for CMS information, such as *Length of Stay (LOS) by Diagnosis and Operation*, United States, published and copyrighted by Solucient, LLC, and recommended by the Division of Workers' Compensation for use by hospitals and insurers.

Appendix C of Solucient's *LOS* Manuals contains a list of ICD-9-CM procedure codes and their CMS-defined operative status.

Except as otherwise provided in this Manual, hospitals shall be reimbursed according to the surgical per diem schedule for each admission wherein the ICD-9-CM primary procedure code is designated as either "operative" or "mixed."

Solucient's *LOS* Manuals may be obtained from Solucient, LLC, 1007 Church Street, Suite 700, Evanston, Illinois 60201 or (800) 568-3282.

Chapter 5 Inpatient Reimbursement Schedules, continued

Per Diem Schedule

If the Total Gross Charge After Implant Carve-Out⁸ is \$51,400.00 or less, reimbursement shall be determined according to the following per diem allowances:

Inpatient services provided by a trauma center, licensed pursuant to s. 395.4025, F.S.:

1. Surgical stay: \$3,305.00 per day;
2. Non-surgical stay: \$1,986.00 per day.

Note: For a list of the Trauma Centers contact information, please see the [DOH web site](#)

Inpatient services provided by other hospitals:

1. Surgical stay: \$3,304.00 per day;
2. Non-surgical stay: \$1,960.00 per day.

- If the charges for any day of hospitalization are less than the applicable per diem allowance established in this Chapter, the hospital shall be reimbursed the per diem allowance for the day(s) rather than the lesser amount charged by the hospital.
- The insurer shall not reimburse a per diem allowance for the day of discharge.
- The insurer shall not disallow a per diem allowance for any day of an inpatient stay unless the documentation in the medical record does not support the medical necessity for each of the estimated number of days that were pre-certified, or the actual length of stay exceeds the estimated days that were pre-certified by the insurer and the medical record does not substantiate the medical necessity for the additional inpatient day(s).

⁸ See definition of Total Gross Charge After Implant Carve-Out in Chapter 11

Chapter 5 Inpatient Reimbursement Schedules, continued

Discharge within 24 Hours of Admission

When a discharge occurs within 24 hours of admission to a hospital facility, reimbursement shall not exceed the applicable per diem allowance for a single day, unless the hospital indicates that the injured employee expired within the 24 hours.

When discharge occurs within 24 hours of admission via the emergency department of the hospital and the injured employee expires, the insurer shall reimburse the hospital either the applicable per diem allowance or 3.95 times the amount Medicare allows under the Outpatient Prospective Payment System (OPPS) pursuant to Chapter 6 of this Manual, whichever is greater.

Exceptions to Per Diem

Before calculating the amount of reimbursement for inpatient services according to this Chapter, charges for surgical implant(s) shall be separated out from the total gross charges for which reimbursement is requested. If the Total Gross Charge After Implant Carve-Out is over \$51,400.00, reimbursement shall be determined according to the **Stop-Loss Method**.

Stop-Loss Reimbursement

If the Total Gross Charge After Implant Carve-Out exceeds \$51,400.00, the hospital shall be reimbursed seventy-five percent (75%) of the Total Gross Charge After Implant Carve-Out, except as otherwise provided in this Manual.

Reporting Charges for Surgical Implants

All hospitals shall report surgical implant charges according to the National Uniform Billing Committee Official UB-04 Data Specification Manual, National Uniform Billing Manual, incorporated by reference into Rule 69L-7.602, F.A.C.

Hospitals shall identify charges for surgical implant(s) and associated disposable instrumentation on the hospital billing form in the required Form Locator by using the designated Revenue Code in accordance and in compliance with the guidelines and definition of "Implantables" and "Examples of Other Implants (not all-inclusive)" provided in the UB-04 National Uniform Billing Manual.

Reimbursement for surgical implants billed under Revenue Code 278, when charged for inpatient hospital services and supplies, shall be determined separately according to Chapter 5 of this Manual.

Note: See **Surgical Implant Reimbursement Formula** in this Chapter.

Chapter 5 Inpatient Reimbursement Schedules, continued

Surgical Implant Reimbursement Formula

Reimbursement for surgical implant(s), also referred to as “implantables” by the National Uniform Billing Manual, required during inpatient hospitalization billed under Revenue Code 278 shall be sixty percent (60%) over the manufacturer’s acquisition invoice cost for the implant(s).

Reimbursement for the associated disposable instrumentation required for the implantation of the surgical implant shall be twenty percent (20%) over the manufacturer’s acquisition invoice cost, if the associated disposable instrumentation is received with the surgical implant and included on the manufacturer’s invoice.

This formula applies regardless of the amount of the charges reported by the billing hospital on the hospital billing form pursuant to Rule 69L-7.602, F.A.C.

Surgical Implants In Addition to Per Diem or Stop Loss

Reimbursement for surgical implant(s) and associated disposable instrumentation shall be in addition to reimbursement of the Total Gross Charge After Implant Carve-Out; whether the charge is reimbursed by the Per Diem Method or the Stop Loss Method.

Note: Contractual arrangements between a hospital and an insurer shall clearly specify the reimbursement amounts for “implantables”.

Determining Implant Acquisition Cost

When determining the acquisition invoice cost of the surgical implant(s), the hospital shall subtract any and all price reductions, offsets, discounts, adjustments and/or refunds which accrue to or are factored into the final net cost to the hospital, only if they appear on the acquisition invoice, before increasing the invoice amount by the percentage factors described above.

Chapter 5 Inpatient Reimbursement Schedules, continued

Request for Implant Reimbursement

In order to receive reimbursement for surgical implant(s) identified and billed in accordance with this Chapter, the hospital shall either:

- Certify that the amount being requested for reimbursement is in accordance with the reimbursement policies in this Chapter, or
- Submit a copy of the invoice(s) for purchase of the surgical implant(s) and associated disposable instrumentation as documentation of the policy above, to the insurer.

Charges billed under the surgical implant(s) Revenue Code that are not accompanied by either method listed above, shall constitute undocumented charges and shall not be reimbursed.

Note: See **Certification of Implant Reimbursement Amount**

Certification of Implant Reimbursement Amount

Certification of a medical bill that the amount requested for reimbursement for the surgical implant(s) billed under Revenue Code 278 does not exceed sixty percent (60%) over the invoice costs as specified in this Chapter may be submitted as follows:

- By a signed, written statement accompanying the request for implant reimbursement amount when submitting paper claims; or
- According to prior written agreement between the billing hospital and the insurer regarding reimbursement for surgical implant(s); or
- Via the hospital billing form when submitting claims electronically or by paper. A hospital electing to submit certification of the implant reimbursement amount via the hospital billing form shall place the amount requested for reimbursement in the Form Locator labeled 'Remarks'. The hospital shall enter "Implants" in the Form Locator immediately preceding the amount of expected reimbursement which is calculated pursuant to this Manual.

Chapter 5 Inpatient Reimbursement Schedules, continued

Verification of Surgical Implant Costs and Charges

The hospital's certification of amounts requested for reimbursement whether by signed statement, by prior agreement or via the hospital billing form in the Form Locator labeled "Remarks", and the hospital's compliance with billing and revenue code specifications in accordance with the National Uniform Billing Manual incorporated by reference into Rule 69L-7.602, F.A.C., shall be subject to verification through audit and medical record review pursuant to Chapter 9 of this Manual.

Upon request by either the Division or by an insurer or its designee, to conduct an audit or medical record review as defined in Chapter 9 of this Manual, the hospital shall produce a copy to the requester or make the original documents available for on-site review, or elsewhere by mutual agreement, such medical record(s) and surgical implant invoice purchasing documentation as requested within thirty (30) days of the request.

Neither a request nor completion of an audit shall toll the time frame for petitioning the Division for resolution of a reimbursement dispute pursuant to s. 440.13(7), F.S.

Nothing in this Manual is intended to create, alter, diminish, or negate any protections regarding the confidentiality of any cost information produced during the course of such an audit.

Chapter 6 Outpatient Reimbursement

Introduction

Pursuant to section 440.13(12)(a), Florida Statutes, all compensable charges for hospital outpatient care shall be reimbursed at 75% of usual and customary charges, except outpatient scheduled surgeries, which shall be reimbursed at 60% of usual and customary charges. Usual and customary charges are to be calculated based on average fees of all providers in a given geographic area. In order to create a transparent and predictable reimbursement process which meets this standard, the Three Member Panel adopted the Medicare Hospital Outpatient Prospective Payment System as the reimbursement methodology for specified hospital outpatient services. This methodology utilizes Medicare payment rates enhanced by payment adjustment factors to meet the statutorily mandated reimbursement levels, and provide transparency and predictability in the reimbursement process.

Outpatient Prospective Payment System

Except as otherwise provided in this Chapter, hospitals are paid using the Medicare⁹ Hospital Outpatient Prospective Payment System¹⁰ (OPPS) payment methodology that is calculated based on assigning outpatient services into ambulatory payment classifications (APCs). Services within an APC are similar clinically and require comparable resources. Each APC is assigned a payment rate based on the median cost of the services within that classification. The payment rates are initially determined on a national basis; however, the rates actually paid to hospitals in an area will vary, depending on the area's wage level. To adjust for wage differences across geographic areas, the labor-related portion of the payment rate (60 percent) is wage adjusted, using the individual hospital's wage index.

Not all procedures are assigned to an APC. If no APC is assigned for a service or procedure, the service or procedure will be reimbursed from one of four fee schedules depending on the procedure code status indicator designated by the Integrated Outpatient Code Editor. The guideline for payment of a service is based on the Medicare allowed amount in effect on the date of service from the:

- Physician Fee Schedule,
- Clinical Laboratory Fee Schedule,
- Durable Medical Equipment Fee Schedule, or
- Ambulance Fee Schedule

Note: See the Centers for Medicare and Medicaid Services (CMS) [CMS web site](#) for more information.

⁹ Medicare, Title XVIII of the Social Security Act.

¹⁰ See Definition of Hospital Outpatient Prospective Payment System in Chapter 11.

Chapter 6 Outpatient Reimbursement, continued

Durable Medical Equipment

Durable medical equipment (DME) shall be reimbursed 3.95 times the Medicare allowed amount from the Medicare Durable Medical Equipment Fee Schedule in effect on the date of service.

Ambulance Services

Hospital-owned ambulance services shall be reimbursed 3.95 times the Medicare allowed amount from the Medicare Ambulance Fee Schedule in effect on the date of service.

Incidental Items and Services

Incidental items and services are packaged into the APC payment. No separate payment is made for packaged services because the cost of these items is included in the APC payment for the services of which they are a primary part. Supplies, anesthesia, recovery room and certain drugs are considered to be a primary part of a surgical procedure and payment for these items is packaged into the APC payment.

Pass-Through Devices

Pass through devices, specified drugs and certain biologicals are only those items considered by the Centers for Medicare and Medicaid Services (CMS) as new or emerging technology that have not yet been considered as packaged into the cost of an APC. The CMS determines an effective date for separate payment in addition to the APC.

Payments for pass-through devices, specified drugs and certain biologicals are limited to at least two years but no more than three years. Payment for pass-through devices is based on the charge on the individual bill, converted to cost by application of a hospital-specific cost-to-charge ratio, and subject (in some instances) to a reduction that offsets the cost of similar devices already included in the APC payment rate for the associated procedure.

When the pass-through payment status for the device category code has expired, hospitals are still required to report device codes on claims when such devices are used in conjunction with procedures billed and paid for under the OPPS.

Note: Devices are subject to the Procedure to Device Edits and the Device to Procedure Edits.

Reimbursement for Devices not Included in APCs

Reimbursement for devices not already included in the reimbursement for an APC shall be based on the charge on the individual bill, converted to cost by application of a hospital specific cost-to-charge ratio from the most current cost reporting period.

Note: To obtain the Hospital Specific cost-to-charge ratio, see [Hospital Specific Impact File](#) from the CMS.

Chapter 6 Outpatient Reimbursement, continued

Payment for More Than One APC

Depending on the services provided, a hospital may be paid for more than one APC during an encounter. However, discounting may be applied according to the particular APCs involved. The Integrated Outpatient Code Editor software determines which APCs are reimbursed a full fee and which APCs are subject to discounting according to the OPPS Rules.

Note: See **Integrated Outpatient Code Editor** for software functionality.

Integrated Outpatient Code Editor

The Integrated Outpatient Code Editor software (IOCE)[®] combines editing logic with the APC assignment program designed to meet the OPPS implementation. The IOCE is revised throughout the year and the version selected for processing a bill is selected based on the date of service.

The software performs the following functions:

- Edits a claim for accuracy of submitted data
- Assigns APCs
- Assigns CMS-designated status indicators
- Assigns payment indicators
- Computes discounts, if applicable
- Determines a claim disposition based on generated edits
- Determines payment adjustment, if applicable.

NCCI Edits

The National Correct Coding Initiative (NCCI) edits are incorporated into the Integrated Outpatient Code Editor software. Quarterly updates to these edits are incorporated into the Integrated Outpatient Code Editor and updated through the revisions to the IOCE. These edits are applied under the OPPS payment methodology to process outpatient hospital claims.

Note: For more information, see [National Correct Coding Initiatives Edits](#)

Chapter 6 Outpatient Reimbursement, continued

Outpatient Hospital Reimbursement Amount

Except as otherwise provided in this Chapter, hospitals shall be reimbursed:

- According to a mutually agreed upon contract between the hospital and the insurer/employer; or
- 3.95 times the Medicare allowed amount reimbursed under its Hospital Outpatient Prospective Payment System for services provided on an outpatient basis when medically necessary.

Note: When an admission occurs as the result of emergency room services, or immediately subsequent to other non-surgical outpatient services, reimbursement for the hospital services shall be subject to the provisions of Chapter 5 of this Manual.

Exception for Scheduled Surgery

Hospital charges for scheduled outpatient surgery shall be reimbursed either:

- A mutually agreed upon contract amount between the insurer or employer and the hospital, or
- 1.74 times the Medicare allowed amount reimbursed under OPPS and shall include all charges for radiology services.

Clinical laboratory services shall only be reimbursed according to the schedule of maximum reimbursement allowances contained in the Florida Workers' Compensation Health Care Provider Reimbursement Manual.¹¹

Hospitals shall make written entry on the hospital billing form to identify whether an outpatient surgery was scheduled or unscheduled.¹²

Note: Reimbursement for a scheduled outpatient surgery that results in the admission of the injured employee to the hospital within 24 hours of the scheduled outpatient surgery shall be subject to the reimbursement provisions of Chapter 5 of this Manual.

Observation Status

Observation services shall be billed using Revenue Code 762 on the hospital billing form in accordance with Rule 69L-7.602, F.A.C.

Note: Outpatient observation services beyond 23 hours are not reimbursable according to Florida Workers' Compensation law.¹³

¹¹ Rule 69L-7.020, Florida Administrative Code

¹² Rule 69L-7.602, Florida Administrative Code

¹³ Subsection 440.13(12), Florida Statutes

Chapter 6 Outpatient Reimbursement, continued

Clinical Laboratory, Radiology, and Therapy Services

Scheduled Non-Emergency Clinical Laboratory and Radiology Services

Scheduled, non-emergency clinical laboratory and radiology services shall be reimbursed according to the schedule of MRAs which applies to non-hospital providers using the Florida Workers' Compensation Health Care Provider Reimbursement Manual (HCP RM), incorporated into Rule 69L-7.020 and Rule 69L-7.501, F.A.C. The General Instructions and Part C of the HCP RM contain MRAs for clinical laboratory services and radiology services.

1. Insurers shall adjust only clinical laboratory and radiology outpatient services identified on the hospital billing form in accordance with Rule 69L-7.602, F.A.C., 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 Chapter 3, Part C, that applies to the technical component of the CPT[®] or HCPCS code reported by the hospital on the hospital billing form in accordance with Rule 69L-7.602, F.A.C.
3. Insurers shall determine the number of units of service reported by the hospital on the hospital billing form in accordance with Rule 69L-7.602, F.A.C. 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 MRA for the specific radiology or clinical laboratory services.

Chapter 6 Outpatient Reimbursement, continued

Physical, Occupational and Speech Therapies

All outpatient physical, occupational and speech therapy services shall be reimbursed according to the schedule of MRAs which applies to non-hospital providers using the Florida Workers' Compensation Health Care Provider Reimbursement Manual (HCP RM), incorporated into Rule 69L-7.020, F.A.C. and Rule 69L-7.501, F.A.C., and further explained in this Manual. The HCP RM, General Instructions and Part C contain MRAs for physical, occupational, and speech therapy services, and Appendix E provides information for determining the applicable non-hospital provider locality.

1. Insurers shall adjust only outpatient physical, occupational, and speech therapy services identified on the hospital billing form in accordance with Rule 69L-7.602, F.A.C., 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 on the hospital billing form in accordance with Rule 69L-7.602, F.A.C.
 3. Insurers shall determine the number of units of physical, occupational, or speech therapy services reported by the hospital for each procedure code on the hospital billing form in accordance with Rule 69L-7.602, F.A.C.
 4. Insurers shall multiply the facility MRA in Part C, by the units of service to determine the outpatient hospital MRA for the specific physical, occupational or speech therapy services.
 5. Provisions of the Physical Medicine and Rehabilitation Services of the HCP RM shall also apply to outpatient therapy reimbursement and are hereby incorporated pursuant to Rule 69L-7.020, F.A.C.
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Chapter 7 Federal and Out-of-State Hospitals

General policy

Except as provided herein, when providing services to injured workers entitled to medical benefits under the Florida Workers' Compensation Law, both federal and out-of- state hospitals shall comply with the Division's Rule(s), including the requirements and procedures established in this Manual.

Federal Hospitals

- Federal hospitals are not subject to the MRA adopted by the Three Member Panel and set forth in Chapters 5 and 6 of this Manual; and
 - May use their customary billing form instead of the form required by Rule 69L-7.602, F.A.C.
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Out-of-State Hospitals

Hospital services provided outside of the state of Florida shall be reimbursed the amount agreed upon by the hospital and the insurer pursuant to obtaining authorization as required by Chapter 3 of this Manual.

If no amount has been pre-approved, the hospital shall be reimbursed the greater of:

- The amount of reimbursement established under the Workers' Compensation statute where the hospital is located; or
 - The MRA as determined using this Manual, including the limitations on reimbursement for radiology, clinical laboratory, and physical, occupational and speech therapies.
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Chapter 8 Disallowed, Denied and Disputed Charges

Reimbursement for Services Unrelated to the Compensable Injury

Insurers shall not reimburse hospital charges for services unrelated to the treatment or care of a compensable injury except for the treatment to stabilize or maintain the patient's medical status in order to treat the patient's compensable injury or condition

Physician Services

The insurer shall not reimburse a hospital for physician or other recognized practitioner services when billed by the hospital on the hospital billing form. Proper billing and reimbursement of physician or other recognized practitioner services rendered in any location, including inside a hospital, shall be in accordance with the requirements of Rule 69L-7.602 and Rule 69L-7.020, F.A.C.

Disallowance and Adjustment of Itemized Charges

Except when reimbursement is according to the per diem allowances set forth in Chapter 5 of this Manual, the insurer shall disallow or adjust reimbursement for any charges that are not documented in the patient's medical record, are not consistent with the hospital's Charge Master or are for the services, treatment or supplies that are not medically necessary for:

1. the treatment of the patient's compensable injury or condition or to stabilize or maintain the patient's medical status in order to treat the patient's compensable injury or condition; or
2. that are not documented in the patient's medical record, are not consistent with the hospital's Charge Master, or are for services, treatment or supplies that are not medically necessary for treatment of the patient's compensable injury or condition.

Timely Payment and Notice of Adjustment, Disallowance or Denial

Notwithstanding the insurer's right to disallow charges, the insurer shall comply with the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule¹⁴ and s. 440.20(2)(b), F.S., that require timely payment, adjustment, disallowance or denial of a hospital bill.

¹⁴ Chapter 69L-7.602, Florida Administrative Code

Chapter 8 Disallowed, Denied and Disputed Charges, continued

Minimum Partial Payment Required

At any time when an insurer denies, disallows or adjusts payment for hospital charges in accordance with the time limitations and coding requirements established by statute¹⁵ and by Rule¹⁶, the insurer shall remit a minimum partial payment of the hospital's charges, which payment shall accompany the Explanation of Bill Review (EOBR). The minimum partial payment required shall be determined as follows:

Per Diem Payments: The insurer shall remit minimum partial payment according to the applicable per diem rate for each inpatient day for which the hospital obtained pre-certification in accordance with Chapter 3 of this Manual, and for which there is no dispute as to the medical necessity of the hospital day.

Stop-Loss Payments: The insurer shall remit minimum partial payment by issuing payment for charges in excess of \$51,400 for which there is no dispute as to the medical necessity of the services and supplies.

Subject to any minimum partial payments required herein, the insurer shall deny, disallow, or adjust payment for charges included in the Total Gross Charge After Implant Carve-Out that do not correspond to the hospital's Charge Master or are for undocumented or medically unnecessary services or supplies as determined in accordance with Chapter 9 of this Manual. If adjustments to the Total Gross Charge After Implant Carve-Out, pursuant to Chapter 9 of this Manual, reduce the Total Gross Charge After Implant Carve-Out to \$51,400.00 or less, reimbursement for the Total Gross Charge After Implant Carve-Out shall be pursuant to the applicable Per Diem Schedule.

Outpatient Payments: The insurer shall remit minimum partial payment according to the applicable reimbursement for each of the APCs or other medical services paid by fee schedule amounts that are not denied, disallowed or adjusted.

Disputing Reimbursement

Upon receipt of an EOBR for less than the anticipated payment from the insurer, the hospital may elect to contest the disallowance or adjustment under s. 440.13(7), F.S.

¹⁵ Subsection 440.20(2)(b), Florida Statutes

¹⁶ Chapter 69L-7.602, Florida Administrative Code

Chapter 9 Charge Master, Medical Record Review or Audit

Hospital Charge Master

The hospital shall produce, or make available for on-site review when requested by the insurer or its designee pursuant to negotiations between the hospital and insurer or its designee regarding a proposed agreement, the hospital's Charge Master as it existed on any date within the most recent twelve (12) months.

The insurer may elect to request copies, subject to copying charges pursuant to Chapter 4 of this Manual, of relevant portions of a hospital's Charge Master and any medical records for in-house desk audit or review or to conduct an audit or review of original documents on-site at the hospital to verify the accuracy of a hospital's charges, billing practices, or medical necessity and compensability of charges for medical services or supplies.

The hospital shall produce copies of the relevant portions of the hospital's Charge Master and any medical records subject to copying charges according to Chapter 4 of this Manual, or make the original documents available on-site, within thirty (30) calendar days of receipt of the written request from either the Department or a insurer or its designee, as part of an audit or review according to this Chapter.

Exit Interview

At the conclusion of the on-site review of documentation, an exit interview shall be conducted by the insurer, if requested by the hospital, concerning the insurer's findings.

Neither a request nor completion of an on-site record review or audit shall toll the time frame for petitioning the Division for resolution of a reimbursement dispute.¹⁷

¹⁷ Reimbursement disputes are addressed in Section 440.13(7), Florida Statutes and Rule 69L-31, Florida Administrative Code.

Chapter 10 Hospital Bill Submission and Forms

Forms for Medical Bill Submission

All medical bills for hospital services shall be submitted on the Form DFS-F5-DWC-90.

Completing the Claim Form

The Form DFS-F5-DWC-90 Completion Instructions are available on the [DWC web site](#).

Provider Use of Codes, Descriptions and Modifiers

Hospitals shall use the codes and descriptions, modifiers, guidelines, definitions and instructions of the referenced CPT[®], CDT[®], HCPCS[®], ICD-9[®], UB-04[®] Manual or Florida Workers' Compensation Unique Codes, modifiers or other materials referenced in this Manual for the appropriate date of service.

The use of HCPCS[®] Level II codes is allowed only when there is not a more specific CPT[®] code available for use.

All ICD-9 codes must be reported at the highest level of specificity according to the ICD-9 required number of digits, i.e. 4th and 5th digits when required by the ICD-CM[®] Manual.

Additional Billing Requirements

In addition to submitting the Form DFS-F5-DWC-90, a hospital must:

- Attach an itemized statement with charges based on the facility's Charge Master; and
 - Submit all documentation or certification requested in writing by the insurer at the time of authorization; and
 - Bill all professional services provided by a physician, physician assistant, advanced registered nurse practitioner, anesthesia assistant or registered nurse first assistant on the Form DFS-F5-DWC-9, regardless of employment arrangement; and
- When entering the CPT, HCPCS or workers' compensation unique code, or modifier in Form Locator 44 on the Form DFS-F5-DWC-90, the hospital shall utilize CPT, HCPCS or workers' compensation unique codes or modifiers referenced in the Florida Workers Compensation Health Care Provider Reimbursement Manual adopted in Rule 69L-7.020, F.A.C.

Chapter 10 Hospital Bill Submission and Forms, continued

Pharmaceutical(s)

Hospitals shall bill using the appropriate Revenue Center Code in Form Locator 42.

Note: If a HCPCS code is required, as indicated either by no entry or a 'Y' in the UB-04 Data Specifications Manual, enter the appropriate HCPCS code in Form Locator 44.

Durable Medical Equipment

Hospitals shall bill using the appropriate Revenue Center Code in Form Locator 42 and enter the appropriate HCPCS code in Form Locator 44.

DWC-90

[DWC-90 Completion Instructions](#)

[Sample Form DWC-90](#)

DWC-25

[DWC-25 Interactive Excel with Instructions](#)

Chapter 11 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) "Authorization" means the approval given to a health care provider by the insurer or self-insured employer for the provision of medical services to an injured employee.
- (3) "Charge Master" means a comprehensive listing of all the goods and services for which the facility maintains a separate charge, with the facility's charge for each of the goods and services, regardless of payer type. The Charge Master shall be maintained and produced when requested for the purpose of verifying usual charges pursuant to s. 440.13(12)(d), F.S.
- (4) "Division" means the Division of Workers' Compensation of the Department of Financial Services as defined in s. 440.02(14), F.S.
- (5) "Health Care Provider" means a provider as defined in s.440.13 (1), F.S.
- (6) "Hospital" means a health care facility as defined in Chapter 395, F.S.
- (7) "Itemized Statement" means a detailed listing of hospital services and supplies as described in s. 395.301, F.S.
- (8) "Hospital Outpatient Prospective Payment System", or OPPTS as used in this Manual, means Medicare's reimbursement method for associating clinically similar services into ambulatory payment classifications (APCs) and adjusting the reimbursement of these service by multiplying the total relative payments of the APCs by the wage index for the provider's location. Certain services, which are not associated with an APC, are reimbursed from the Medicare Physician Fee Schedule, the Clinical Laboratory Fee Schedule, the Durable Medical Equipment Fee Schedule or the Ambulance Fee Schedule depending on the status indicator of the procedure code. Pass-through items and devices are reimbursed using the hospital specific cost-to-charge ratio.
- (9) "Medical Record" means patient records maintained in accordance with form and content required under Chapter 395, F.S.
- (10) "Medical Record Review" means a review of the medical record of the injured employee in order to verify the medical necessity of the services and care as they relate to the itemized statement for a specific bill.
- (11) "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.
- (12) "Physician" means a physician as defined in s. 440.13(1) (q), F.S.

(13) "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 when the Total Gross Charge or the Total Gross Charge After Implant Carve-Out exceeds \$51,400. The methodology allows reimbursement of 75 percent (75%) of the hospital's charges for medically necessary services except for surgical implant(s).

(14) "Surgical Stay" means an admission for which the CMS-defined operative status for the primary procedure reported by the hospital on the hospital billing form is designated as either "operative" or "mixed."

(15) "Total Gross Charge" means the sum of all charges entered on the hospital billing form during the covered period identified on the hospital bill.

(16) "Total Gross Charge After Implant Carve-Out" means the Total Gross Charge identified on the hospital bill less the sum of all charges for implants billed pursuant to Rule 69L-7.602, F.A.C.

(17) "Trauma Center" means a hospital approved for certification as a trauma center pursuant to Rule 64E-2.06, F.A.C. A list of certified trauma centers is available free of charge from the [Florida Department of Health](#).
