

Florida Workers' Compensation
Reimbursement Manual for Ambulatory Surgical
Centers

Rule 69L-7.100, F.A.C.

2015 Edition



Effective 01/01/2016

THIS PAGE LEFT INTENTIONALLY BLANK

TABLE OF CONTENTS

CHAPTER 1 INTRODUCTION AND OVERVIEW 5

E-Alert System..... 5

Overview 6

How to Obtain or Purchase Hard Copy Manuals..... 6

Manual Use and Format..... 7

Manual Updates 7

Identifying New Material 8

CHAPTER 2 PROGRAM REQUIREMENTS 9

Introduction and Purpose..... 9

Prior Authorization of Services 10

Provider Use of Codes, Descriptions, and Modifiers 11

Charge Master, Medical Record Review or Audit..... 12

Medical Records for Reimbursement..... 12

Copies of Medical Records 13

Procedure Components 14

Reimbursement of Components..... 14

CHAPTER 3 DESCRIPTION OF ASC FACILITY SERVICES..... 15

ASC Facility Services..... 15

Services Included in ASC Fee 15

ASC Services and Components..... 16

Determining Reimbursement Amounts 17

Reimbursement for Surgical Services 17

Pathology/Laboratory Services..... 18

Surgical Implant Reimbursement..... 19

**Florida Workers' Compensation Reimbursement Manual for
Ambulatory Surgical Centers**

Billing for Surgical Implant(s)	19
Documentation for Surgical Implant Charges	21
Certification of Surgical Implant Reimbursement Amount.....	22
Multiple Surgery Reimbursement Amount	23
Billing and Reimbursement for Bilateral Procedures.....	23
Reimbursement for Bilateral Procedures Not Listed as Bilateral in CPT®	24
Bilateral Procedures Performed Unilaterally.....	25
Post Operative Pain Management	25
Terminated Procedures	26
Reimbursement for Terminated Procedures.....	26
Out-of-State Facility.....	27
CHAPTER 4 DISALLOWED, DENIED AND DISPUTED CHARGES.....	28
CHAPTER 5 BILLING INSTRUCTIONS AND FORMS.....	29
CHAPTER 6 MAXIMUM REIMBURSEMENT ALLOWANCES (MRA)	34
CHAPTER 7 DEFINITIONS.....	35
CHAPTER 8 FORM DFS-F5-DWC-90 COMPLETION INSTRUCTIONS	37
APPENDIX A	38
WORKERS' COMPENSATION UNIQUE PROCEDURE CODES	38

Chapter 1 Introduction and Overview

Changes to the Manual

Approved changes to the Manual will be sent out as electronic updates via the Division of Workers' Compensation E-Alert system. An update can be an approved change, addition, or correction to the Manual. Updates will be available under the 'Manuals' section on the [DWC web site](#).

It is important that Ambulatory Surgical Centers (ASCs) and carriers read the updated material and file new material in the Manual. Both parties have a responsibility for performing specific duties when billing, reporting, or reimbursing medical services rendered to injured workers.

E-Alert System

The Division has an electronic alert system to notify subscribers of 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 "Register" on the right. Once registered, you shall receive E-Alerts whenever they are provided by the Division.

Explanation of the Update Log

ASCs and carriers can use the update log to determine if all of the updates to the Manual have been received.

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

Effective Date is the date that the update is effective.

Instructions

1. File the new pages, Chapters or new Manual as instructed.
2. File the new update log.

UPDATE NO.	EFFECTIVE DATE
2011	November 13, 2011
2015	TBD

Chapter 1 Introduction and Overview, continued

Overview

Preface

This chapter introduces the format used for the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers and tells the reader how to use the Manual.

Background

There are 3 types of Workers' Compensation Manuals:

- Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100 Florida Administrative Code (F.A.C.);
 - Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C., and
 - Florida Workers' Compensation Reimbursement Manual for Hospitals, Rule 69L-7.501, F.A.C.
-

Other Applicable Rules

In addition to this Manual, the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, F.A.C., also recognizes the following resources:

- The Florida Workers' Compensation Medical Reimbursement and Utilization Review, Chapter 69L-7, F.A.C., and
 - Materials Incorporated by Reference for use in Florida's Workers' Compensation, Chapter 69L-8, F.A.C.
-

How to Obtain or Purchase Hard Copy Manuals

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

Chapter 1 Introduction and Overview, continued

Manual Use and Format

Format

The format style used in the Manual represents 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.

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".

Manual Updates

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

Chapter 1 Introduction and Overview, continued

Manual Use and Format, continued

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 of the label and right of 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. |

New material within a list of bullets will be indicated in this manner.

- | • New Material |
-

Chapter 2 Program Requirements

Introduction and Purpose

The Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers contains the Maximum Reimbursement Allowances (MRAs) for surgical procedures performed in the Ambulatory Surgical Center setting and defines a payment method for surgical and non-surgical services not defined in the fee schedule.

Unless otherwise specified in this manual, the terms "insurer" and "carrier" are used interchangeably and have the same meanings as defined in subsection 440.02, F.S., and may also refer to a service company, third party administrator (TPA) or any other entity acting on behalf of an insurer for the purposes of administering workers' compensation benefits for its insured(s).

The carrier 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 reimbursements to ASCs.

Carrier Responsibilities

A carrier is responsible for meeting its obligations under this rule regardless of any business arrangements with any service company/TPA, submitter, or any entity acting on behalf of the carrier under which claims are paid, adjusted and paid, disallowed, denied, or otherwise processed and submitted to the Division.

Chapter 2 Program Requirements, continued

Prior Authorization of Services

Florida ASC facilities and out-of-state facilities must be authorized by the workers' compensation carrier or a self-insured employer prior to:

- Rendering initial care, remedial medical services and pharmacy services; or
- Making a referral for the injured worker to facilities or other health care providers.

Note: Exceptions to prior authorization are:

- Federal facilities;
- Emergency room services and care, defined in s. 395.002, F.S.; or
- A provider referral for emergency treatment resulting from emergency services.

Documenting Prior Authorization

The ASC shall record the authorization in the injured worker's medical record or in the ASC's billing or financial record(s) and shall include:

- The date(s) on which the authorization was requested and received (whether verbally or in writing); and
 - The name of the carrier or its designated entity; and
 - The name of the person authorizing the ASC services.
-

Chapter 2 Program Requirements, continued

Provider Use of Codes, Descriptions, and Modifiers

The codes and descriptions used to report medical treatment to injured workers shall be the codes and descriptions listed in the documents incorporated by reference in Rule 69L-8.072, F.A.C.

An ASC shall use the codes and descriptions, modifiers, guidelines, definitions and instructions of the incorporated reference material as specified in Chapter 69L-7, F.A.C. and the following completion instructions:

- Form DFS-F5-DWC-9-C Completion Instructions for Ambulatory Surgical Centers, Rev.01/01/2015 (only for dates of service prior to July 8, 2010); or
- DFS-F5-DWC-90-B (UB-04) Form Completion Instructions for Ambulatory Surgical Centers, Rev. 01/01/2015 (only for dates of service on or after 07/08/2010)

All diagnosis codes must be reported to the highest level of specificity according to the diagnosis code-in the ICD[®] Manual.

Carrier Use of Codes, Descriptions, and References

Carriers shall use the codes and descriptions, guidelines and instructions of the incorporated reference material as specified in Rule 69L-8.072, F.A.C. prior to making reimbursement decisions.

Chapter 2 Program Requirements, continued

Charge Master, Medical Record Review or Audit

Verifying Accuracy of Charges, Medical Necessity or Compensability

An ASC shall produce, or make the documents available for on-site review, of the relevant portions of the ASC Charge Master and any and all applicable medical records when requested by the Division, by a carrier or by its designee, as part of an on-site audit to verify accuracy of the ASC charges, billing practices, or medical necessity and compensability of charges for medical services and supplies.

Division Requests

An ASC shall provide medical record(s) and relevant portions of the Charge Master(s) to the Division upon request without charge.

Exit Interview

At the conclusion of an on-site review of documentation, an exit interview concerning the carrier's findings shall be conducted by the carrier, or its designee, if requested by the ASC, in a manner agreed upon by both parties.

Time Frames

Neither a request nor completion of an on-site record review or an audit shall toll the time frame for payment of a medical claim or petitioning the Division for resolution of a reimbursement dispute pursuant to s. 440.13(7), F.S. and s. 440.20(2)(b), F.S.

Medical Records for Reimbursement

Disclosure to Carriers

At a minimum, it is the responsibility of the ASC to furnish, without charge, the following documentation to the carrier with the ASC bill:

- An operative report when a surgical procedure is performed; and
- Surgical Implant(s), Associated Disposable Instrumentation and Shipping & Handling Invoices, when applicable; and
- Any copies of medical records required by the employer or carrier, that the ASC received written notification from the employer or carrier as being a required component for reimbursement, when the services were authorized.

Failure of the ASC to forward additional information, when requested by the employer/carrier at the time of authorization, may result in the billed service(s) being disallowed or denied for payment until sufficient documentation is provided to render the determination.

Chapter 2 Program Requirements, continued

Copies of Medical Records

Injured Worker's Request

An ASC shall, upon written request, furnish an injured worker or the injured worker's attorney a copy of the injured worker's medical records and reports. Reimbursement for medical reports shall be made to an ASC requested by the injured worker or the injured worker's representative at no more than \$0.50 per page.

An ASC shall, upon written request, furnish the injured worker or the injured worker's attorney non-written medical records. Reimbursement shall be made to an ASC by the requesting party at the provider's actual direct cost for x-rays, microfilm, or other non-written records.

Carrier Requests

An ASC shall, upon request, furnish an carrier or the carrier's attorney a copy of the injured worker's medical records and reports.

An ASC, upon request, shall furnish the carrier or the carrier's attorney, non-written medical records.

Division or Judge of Compensation Claims Requests

An ASC shall provide, upon request, medical records to the Division or a Judge of Compensation Claims without charge.

Limits on Copying Charges

The limits on copying charges apply regardless of whether the retrieval and copying are performed in-house or are contracted out for completion by a copy service or other medical record maintenance service, and also apply when the carrier requires an ASC to submit medical records not routinely required with a bill in order for payment to be made.

Chapter 2 Program Requirements, continued

Procedure Components

There are three (3) primary components in the total cost of performing a surgical procedure in an ASC:

Professional Fee(s): The cost of professional services furnished by physicians and other recognized health care practitioners for performing the procedure;

Facility Fee(s): The cost of facility services furnished by the ASC facility where the procedure is performed (for example, surgical supplies, equipment and nursing services); and

Surgical Implant Fee(s): The cost of the Surgical Implant(s) which includes the cost of the Surgical Implant(s), the Associated Disposable Instrumentation required for implantation of the device included on the same acquisition invoice for the Surgical Implant(s) and Shipping & Handling.

Reimbursement of Components

Professional Fee(s) are billed by the licensed practitioners according to the Florida Workers' Compensation Health Care Provider Reimbursement Manual and reimbursed to the health care provider.

Facility Fee(s) are billed by the ASC and reimbursed to the ASC according to the policies in this Manual.

Surgical Implant Fee(s), when the Implant(s) are purchased by the ASC, are billed only by the ASC and reimbursed to the ASC according to the policies for Surgical Implant(s) in this Manual.

Chapter 3 Description of ASC Facility Services

ASC Facility Services

ASC facility services include all services and supplies required for the surgery and the procedures performed in connection with a covered surgical procedure performed in an ASC with the exception of items reimbursed pursuant to the policies outlined for Surgical Implants, Associated Disposable Instrumentation and Shipping and Handling in this Manual.

Services Included in ASC Fee

ASC facility services include, but are not limited to, the following:

- Nursing and technical personnel services and other related services;
- Use of the operating and recovery rooms, patient preparation areas, waiting room, and other areas used by the patient or offered for use by the patient's relatives, attendants or companions, or other person(s) accompanying the injured worker in connection with surgical services;
- Drugs, biologicals, intravenous fluids and tubing, surgical dressings, splints, casts, surgical supplies and equipment (required for both the patient and the ASC personnel, e.g., fiber optic scopes and the associated supplies, gowns, masks, drapes, case pack and their contents, operating and recovery room equipment) commonly furnished by the ASC in connection with the surgical procedure;
- Diagnostic and pre-operative testing many ASCs perform simple test(s) on the date of surgery, such as urinalysis, blood hemoglobin or hematocrit, blood glucose or venipuncture to obtain specimens which are included in the ASC facility charges;
- ASC facility reimbursement also includes materials for conscious sedation and general anesthesia including the anesthesia pharmaceuticals and any materials, whether disposable or reusable, necessary for its administration.

Chapter 3 Description of ASC Facility Services, continued

ASC Services and Components

Non-ASC Facility Services

Non-ASC facility services include a number of items and services furnished in an ASC that shall be reimbursed under other Florida Workers' Compensation Manuals and are not reimbursable to an ASC facility.

The following are examples of non-ASC facility services that must be billed and reimbursed to those providers under other Florida Workers' Compensation Reimbursement Manual policies and guidelines:

- Physician and other recognized health care practitioner services;
- Sale, lease, or rental of durable medical equipment for ASC patients to use at home;
- Services furnished by an independent laboratory; and
- Hospital-based Ambulance services.

Note: Please refer to [DWC web site](#) for the other Reimbursement Manuals that provide policy, reimbursement, coverage and guidelines located under the heading 'Provider'.

Chapter 3 Description of ASC Facility Services, *continued*

Determining Reimbursement Amounts

Physician or Other Recognized Health Care Practitioner Services

The carrier shall not reimburse an ASC for any physician or other recognized health care practitioner services when billed by the ASC on the ASC billing form. Proper billing and reimbursement of physician or other recognized health care practitioner services rendered in any location, including inside an ASC, shall be in accordance with the requirements of Rule 69L-7, F.A.C. These services are not reimbursable to an ASC facility.

Reimbursement for Surgical Services

For each billed CPT® code listed in [Chapter 6](#) of this Manual, the ASC shall be reimbursed either:

- The MRA if listed in Chapter 6 of this Manual; or
- The agreed upon contract price.

For each billed CPT® code not listed in Chapter 6 of this Manual, the ASC shall be reimbursed:

- Sixty percent (60%) of the ASC's billed charge; or
- The agreed upon contract price.

Reimbursement for Surgical Implant(s), Terminated Procedures, and Bilateral Procedures Performed Unilaterally shall be as further specified in this Manual.

Note: If there is an agreed upon contract between the ASC and the carrier, the contract establishes the reimbursement at the specified contract price.

Chapter 3 Description of ASC Facility Services, continued

Determining Reimbursement Amounts, continued

Pathology/Laboratory Services

Pathology or laboratory services provided by an Independent Clinical Laboratory shall be billed and reimbursed directly to the laboratory service provider according to the fee schedule in Rule 69L-7.020, F.A.C. The ASC shall also be reimbursed for procedure code 36415 for the collection of a blood specimen that must be conveyed to an independent laboratory pursuant to the fee schedule in Rule 69L-7.020, F.A.C.

Pre-admission pathology or laboratory services, when required by the physician and performed by the ASC on a date other than the date of surgery, shall be reimbursed in accordance with the Fee Schedule established for health care providers in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C.

Radiology/Imaging Services

Pre-admission radiology services, when required by the physician and performed by the ASC on a date other than the date of surgery, shall be reimbursed in accordance with the Fee Schedule established for health care providers in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C.

Radiology/imaging procedures that are performed by the ASC on the day of the surgery are reimbursed separately.

For each billed CPT® code listed in Chapter 6 of this Manual, the ASC shall be reimbursed either:

- The MRA if listed in Chapter 6 of this Manual; or
- The agreed upon contract price,

For each billed CPT® code not listed in Chapter 6 of this Manual, the ASC shall be reimbursed:

- Sixty percent (60%) of billed charges; or
- The agreed upon contract price.

Radiology or Imaging services shall be billed with the appropriate 5-digit CPT® procedure code and appended with a modifier TC.

Note: Reimbursement for Fluoroscopic Guidance is limited to one unit of service per spinal region; not per level.

Chapter 3 Description of ASC Facility Services, continued

**Surgical Implant
Reimbursement**

Surgical Implant(s) shall be itemized separately from the surgical procedure code(s) and are reimbursed in addition to the surgery.

The ASC shall be reimbursed for the Surgical Implant(s) at fifty percent (50%) over the acquisition invoice cost;

The ASC shall be reimbursed for the Associated Disposable Instrumentation *required for implantation* of the Implant(s) at twenty percent (20%) over the acquisition invoice cost, if the Associated Disposable Instrumentation is received with the Surgical Implant(s) and included on the same implant acquisition invoice. Associated Disposable Instrumentation is only reimbursable for those surgeries requiring Surgical Implants;

The ASC shall be reimbursed for Shipping and Handling at the actual cost to the ASC if listed on the invoice.

Note: Surgical Implants, Associated Disposable Instrumentation and Shipping and Handling may be certified for the amount requested for reimbursement pursuant to the percentages stated in this policy.

Billing for Surgical Implant(s)

Surgical Implant(s) shall only be billed using Revenue Code 278 using the Workers' Compensation unique procedure and modifier code: 99070 IM.

Associated Disposable Instrumentation required for implantation of the Surgical Implant(s) shall only be billed using Revenue Code 278 using the Workers' Compensation unique procedure and modifier code: 99070 DI.

Shipping and Handling shall only be billed using Revenue Code 278 using the Workers' Compensation unique procedure and modifier code: 99070 SH. The Workers' Compensation unique procedure codes and their required modifiers stated above shall be billed on separate lines in Form Locator 44.

Note: Instructions contained in Chapter 69L-7, F.A.C, the Workers' Compensation Medical Reimbursement and Utilization Review, shall be used to bill Surgical Implant(s), Associated Disposable Instrumentation, and Shipping and Handling in Form Locator 42 of the Form DFS-F5-DWC-90 (UB-04) claim form.

Chapter 3 Description of ASC Facility Services, continued

Determining Reimbursement Amounts, continued

Determining Surgical Implant Acquisition Cost

When determining the acquisition cost for Surgical Implant(s), the ASC 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 ASC, only if they appear on the acquisition invoices, before increasing the invoice amount by the percentage factors described in the **Surgical Implant(s) Reimbursement** in this Chapter.

Note: See **Verification of Surgical Implant(s) Costs and Charges** later in this Chapter.

Request for Surgical Implant Reimbursement

In order to receive reimbursement for Surgical Implant(s) and their associated costs, the ASC must either:

- Certify in writing on the DFS-F5-DWC-90 (UB-04) billing form, in Form Locator 80 [Remarks], the total requested reimbursement by each category of Surgical Implant(s), Associated Disposable Instrumentation, and Shipping & Handling has been determined in accordance with the reimbursement percentages defined by the policy in this Chapter. Each such total amount requested for reimbursement must be listed separately on the DFS-F5-DWC-90 (UB-04) claim form in the Form Locator 80 [“Remarks”], using each of the modifiers prescribed in this Manual and their associated total dollar amounts of requested reimbursement pursuant to this chapter; or
 - Submit copies of the Implant Log or Tracking Sheet from the operating room to the carrier along with the acquisition invoice(s) that substantiate the utilization and cost of the items(s) billed.
-

Chapter 3 Description of ASC Facility Services, continued

Documentation for Surgical Implant Charges

Charges for Surgical Implant(s) that are not properly certified, not separately identified by each category, or submitted without invoices and implant logs as described above shall constitute undocumented charges and may be adjusted or disallowed.

Note: See **Certification of Surgical Implant Reimbursement Amount** later in this chapter.

Note: Instructions contained in Chapter 69L-7, F.A.C, Workers' Compensation Medical Reimbursement and Utilization Review shall be used to bill Surgical Implant(s), Associated Disposable Instrumentation, and Shipping and Handling in Form Locator 42 of the Form DFS-F5-DWC-90 (UB-04) claim form. The Workers' Compensation unique procedure codes and their required modifiers stated above shall be billed on separate lines in Form Locator 44.

Verification of Surgical Implant(s) Cost and Charges

The ASC certification of the amount requested for reimbursement, whether in writing, by prior written agreement with the carrier, or by the billing form, and the ASC compliance with the billing requirements in this Manual and Chapter 69L-7, F.A.C., the Workers' Compensation Medical Reimbursement and Utilization Review shall be subject to verification through audit and medical record review.

Upon request by the Division for a carrier or its designee to conduct an audit or medical record review, the ASC shall produce a copy of the implant acquisition invoice for the requestor at no charge or make the original documents available for an on-site review, or other location by mutual agreement, within thirty (30) days of the request.

Chapter 3 Description of ASC Facility Services, continued

**Certification of Surgical
Implant Reimbursement
Amount**

Certification of a medical bill that the amount requested for reimbursement of the Surgical Implant(s) billed using Revenue Code 278 is fifty percent (50%) over the acquisition invoice cost, and Associated Disposable Instrumentation is twenty percent (20%) over the acquisition invoice cost.

The documentation for the Associated Disposable Instrumentation must be contained on the invoice for the Implant(s). Shipping and Handling is at the actual cost to the ASC. Certification as specified in this Chapter shall be submitted as follows:

- Via the ASC billing form when submitting claims electronically or by paper;
- Pursuant to a prior written agreement between the ASC and the carrier regarding the reimbursement for Surgical Implant(s), Associated Disposable Instrumentation and Shipping and Handling; or
- By a signed, written statement accompanying the request for reimbursement declaring that the reimbursement amount requested is the percentage pursuant to the policy in this Manual for Surgical Implant(s), Associated Disposable Instrumentation and Shipping and Handling.

An ASC electing to submit certification of the Surgical Implant, Associated Disposable Instrumentation and Shipping and Handling reimbursement amount via the ASC billing form shall place the amount requested for reimbursement in the Form Locator 80 [Remarks].

The ASC shall separately list the abbreviation of each category in the Form Locator 80 of the DFS-F5-DWC-90 (UB-04) claim form immediately preceding the amount of expected reimbursement for each category used which is calculated pursuant to this Manual. Each category shall be identified by the modifiers for Surgical Implants (IM), Associated Disposable Instrumentation (DI), and Shipping and Handling (SH) and the amount of expected reimbursement for each category pursuant to the policy.

An example would be:

<small>80 REMARKS</small>	<small>81CC</small>
IM=\$2,800 DI=\$1,200	a
SH=\$50.00	b
Total=\$4,050.00	c
	d

UB-04 CMS-1450 APPROVED OMB NO.

Chapter 3 Description of ASC Facility Services, continued

Determining Reimbursement Amounts, continued

Multiple Surgery Reimbursement Amount

Reimbursement shall be made for all medically necessary surgical procedures when more than one (1) procedure is performed at a single operative session. Each surgical procedure performed shall be identified by using the appropriate five-digit CPT[®] code and listed separately.

The surgical procedure code listed first shall not be appended with modifier 51. Each additional surgical procedure code shall be listed separately and appended with modifier 51. Reimbursement shall be made consistent with the requirements of

Reimbursement for Surgical Services described earlier in this Manual.

Billing and Reimbursement for Bilateral Procedures

Bilateral procedures listed as bilateral in CPT[®] are exempt from billing with modifier 50. Bill with the appropriate procedure code on one line of the claim form without appending a modifier 50.

Reimbursement shall be made for bilateral procedures listed as bilateral in CPT[®] as follows:

The ASC shall be reimbursed either:

1. The MRA if the procedure code is listed in Chapter 6; or
2. Sixty percent (60%) of the billed charge if not listed in Chapter 6; or
3. The agreed upon contract price.

Chapter 3 Description of ASC Facility Services, continued

Procedures performed bilaterally, that do not contain the word "bilateral" in CPT[®] require a modifier to identify they are performed bilaterally for proper reimbursement.

Bill the five digit procedure code on two separate lines and append the second line procedure code with modifier 50.

Reimbursement for Bilateral Procedures Not Listed as Bilateral in CPT[®]

Reimbursement shall be made for bilateral procedures not listed as bilateral in CPT[®] as follows:

For surgical procedures listed in Chapter 6, the ASC shall be reimbursed either:

1. The MRA; or
2. The agreed upon contract price,

For surgical procedures not listed in Chapter 6, the ASC shall be reimbursed either:

1. Sixty percent (60%) of billed charges; or
2. The agreed upon contract price.

Chapter 3 Description of ASC Facility Services, continued

Bilateral Procedures Performed Unilaterally

When a procedure is performed unilaterally, and the procedure description in CPT[®] states “bilateral”, the service shall be identified with a modifier 52.

Note: Reimbursement shall be 50% of the Reimbursement for Surgical Services described earlier in the manual.

Post Operative Pain Management

Nerve blocks for post operative pain management shall be reimbursed if ordered by the surgeon and is provided in addition to general anesthesia or conscious sedation. They may be performed pre-operatively, intra-operatively, or post-operatively. The health care practitioner performing the nerve block must provide a separate procedure report and submit the documentation to the Carrier for reimbursement.

Carrier reimbursement for post operative Nerve Blocks shall be made consistent with the requirements of **Reimbursement for Surgical Services** earlier in this Manual.

The professional component for nerve blocks shall be billed by the health care practitioner on the DFS-F5-DWC-9 (CMS-1500) claim form.

Chapter 3 Description of ASC Facility Services, continued

Terminated Procedures

A bill submitted for reimbursement of a terminated surgery must include documentation that specifies the following:

1. Reason for termination of surgery;
2. Services, reported by CPT[®] code, that were actually performed or;
3. A single CPT[®] code for the procedure had the scheduled surgery been performed.

Modifier 73 or 74 must be added to the procedure codes scheduled to be performed or actually performed to identify the circumstances under which the services were terminated consistent with CPT coding rules.

Reimbursement for Terminated Procedures

Terminated Procedures shall be made consistent with the following requirements:

1. Reimbursement shall not be made for a procedure terminated either for medical reasons or non-medical reasons before the pre-operative procedures are initiated by staff.
2. Reimbursement shall be fifty percent (50%) of the Reimbursement for Surgical Services if a procedure is terminated due to the onset of medical complications after the patient has been taken to the operating suite, but before anesthesia has been induced. Bill using modifier 73.
3. Reimbursement shall be one hundred percent (100%) of the Reimbursement for Surgical Services if a procedure is terminated due to a medical complication that arises causing the procedure to be terminated after induction of anesthesia. Bill using modifier 74.

Chapter 3 Description of ASC Facility Services, continued

Determining Reimbursement Amounts, continued

Out-of-State Facility

ASC services provided by an out-of-state facility require prior authorization by the carrier.

An ASC outside the state of Florida shall be reimbursed the amount mutually agreed upon in a contract between the ASC and the carrier during the authorization process.

If reimbursement is not agreed upon prior to rendering the service, reimbursement shall be the greater of:

- The requirements of **Reimbursement for Surgical Services** described earlier in this Manual; or
- The reimbursement amount of the state in which the service(s) are rendered.

Disallowance and Adjustment of Itemized Charges

The carrier shall disallow or adjust reimbursement for any charges that are:

- Billed with Category II or Category III CPT[®] procedure codes that are not specifically authorized by the workers' compensation carrier or a self-insured employer prior to the procedure; or
 - Not documented in the patient's medical record; or
 - Not consistent with the ASC's Charge Master; or
 - For services, treatment or supplies that are not medically necessary for treatment of the patient's compensable injury or condition; or
 - For services unrelated to the treatment or care of a compensable injury.
-

Chapter 4 Disallowed, Denied and Disputed Charges

Timely Payment and Notice of Adjustment, Disallowance or Denial

Notwithstanding the carrier's right to disallow or adjust charges, the carrier shall comply with the Florida Workers' Compensation Medical Reimbursement and Utilization Review, Chapter 69L-7, F.A.C. and s. 440.20(2)(b), F.S., that requires timely payment, adjustment, disallowance or denial of an ASC bill.

Minimum Partial Payment Required

At any time an carrier denies, disallows or adjusts payment for ASC charges, in accordance with the time limitation and coding requirements established by Chapter 69L-7, F.A.C. and s. 440.20(2)(b), F.S., the carrier shall remit a minimum partial payment of the ASC charges and the minimum partial payment shall accompany an Explanation of Bill Review (EOBR).

Reimbursement Disputes

The ASC may elect to contest the disallowance or adjustment of payment under s. 440.13(7), F.S. and Chapter 69L-31, F.A.C.

The election to contest the disallowance or adjustment of payment under s. 440.13(7), F.S., must be made by the ASC within forty-five (45) days of receipt of the EOBR or notice of disallowance or adjustment of payment.

Chapter 5 Billing Instructions and Forms

Bill Submission, Filing and Reporting Requirements

ASC Requirements

All ASCs are required to meet their obligations under this Manual, regardless of any business arrangement with any entity under which claims are prepared, processed or submitted to the carrier.

Additional Information Requested by Carrier

All ASCs are required to submit any additional form completion information and supporting documentation requested in writing, by the carrier, service company/TPA or any other entity acting on behalf of the carrier, at the time of authorization.

Bill Completion

An ASC bill shall be properly completed according to the Form completion instructions incorporated in Rule 69L-7.720(1)(e), F.A.C. Form DFS-F5-DWC-90 (UB-04), incorporated in Rule 69L-8.072, F.A.C., shall be legibly and accurately completed by all ASCs.

A carrier can require an ASC to complete additional data elements that are not required by the Division on Form DFS-F5-DWC-90 (UB-04) only if such data elements are necessary for the adjudication and proper reimbursement of services reported. The carrier must request this information in writing at the time of authorization.

Chapter 5 Billing Instructions and Forms, continued

Billing on the DWC-90

ASCs shall bill using Form DFS-F5-DWC-90 (UB-04).

Form DFS-F5-DWC-90-B (UB-04) is the set of instructions for completing the form.

Billing for a Compensable Injury

All medical claim form(s) for medical bill(s) related to services rendered for a compensable injury shall be submitted by an ASC, or any entity acting on behalf of an ASC, to the carrier, service company/TPA or any entity acting on behalf of the carrier, as a requirement for billing.

Methods for Billing

Medical claim form(s) or medical bill(s) may be electronically filed or submitted via facsimile by an ASC to the carrier, service company/TPA or any entity acting on behalf of the carrier, provided the carrier agrees.

Bill Corrections

ASCs are responsible for correcting and resubmitting any billing forms returned by the carrier, service company/TPA or any entity acting on behalf of the carrier pursuant to Chapter 69L-7, F.A.C.

Charge Master

Each ASC shall maintain its Charge Master and shall produce relevant portions when requested for the purpose of verifying its usual charges pursuant to s. 440.13(12)(d), F.S.

Chapter 5 Billing Instructions and Forms, continued

FORM DFS-F5-DWC-90 (UB-04)

Official Guidelines for Billing

All ASCs shall complete the Form DFS-F5-DWC-90 (UB-04) according to the instructions incorporated in Chapter 69L-7, F.A.C. Form DFS-F5-DWC-90-B (UB-04) is the set of instructions for completing the form as incorporated in Chapter 69L-7, F.A.C.

Follow this link below to access the form completion instructions available on the [DWC web site](#).

Revenue Codes for Billing

An ASC shall report Revenue Codes in Form Locator 42 in addition to CPT[®] codes or Workers' Compensation Unique procedure codes in Form Locator 44, where indicated.

When reporting multiple procedures performed during a single operative session, an ASC shall report the appropriate Revenue Code in Form Locator 42 on each line with the corresponding CPT[®] code in Form Locator 44. Modifiers shall be used, when appropriate.

Note: CPT[®] or Workers' Compensation Unique procedure codes are required in Form Locator 44 unless the Revenue Code billed does not require a procedure code pursuant to the UB-04 Data Specifications Manual incorporated by reference in Rule 69L-8.072, F.A.C.

Chapter 5 Billing Instructions and Forms, continued

Surgical Implant(s) Billing

Surgical Implants must be billed using only Revenue Code 278 in Form Locator 42.

The following Workers' Compensation unique procedure code(s) with required modifiers must be billed in Form Locator 44 for proper reimbursement:

Surgical Implants – 99070 IM
Associated Disposable Instrumentation – 99070 DI
Shipping & Handling – 99070 SH

- 1) Manufacturer's acquisition invoices reflecting the ASC's actual cost for the Implants shall accompany the bill for the reimbursement of each component. All such invoices must be clearly marked identifying what components of Surgical Implants, Associated Disposable Instrumentation, and Shipping and Handling are actually used during the surgery. Calculation of the total amounts of each separate category of IM, DI and SH is required on the invoices.
- 2) In lieu of submitting invoices, the requested reimbursement amount for Surgical Implants may be certified in Form Locator 80. If an ASC elects to certify the amount requested for reimbursement of Surgical Implants, Associated Disposable Instrumentation and Shipping & Handling, the amount(s) requested for reimbursement pursuant to the policy in Chapter 3 of this Manual shall be entered in Form Locator 80. The requested amount for each category shall be entered immediately after the abbreviation of each category, i.e. Surgical Implant(s) (IM), Associated Disposable Instrumentation (DI), Shipping and Handling (SH).

Note: See Appendix A for a list of the Workers' Compensation Unique Procedure Codes.

The use of Workers' Compensation Unique Procedure Codes, as specified in this Manual, takes precedence over the UB-04 Data Specifications Manual and CPT® Codes for reporting of designated services.

Chapter 5 Billing Instructions and Forms, continued

SAMPLE DFS-F5-DWC-90 (UB-04) CLAIM FORM

1		2		3a PAT. CNTL.#		3b MED. REC.#		5 FED.TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH																			
8 PATIENT NAME				9 PATIENT ADDRESS																											
10 BIRTHDATE		11 SEX	12 DATE		13 ADMISSION TRANSFER	14 TYPE	15 SFIC	16 DHR	17 STAT	18	19	20	21	22 CONDITION CODES		23	24	25	26	27	28	29 ACCT STATE	30								
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 CODE		36 OCCURRENCE SPAN FROM		37 THROUGH		38 CODE		39 OCCURRENCE SPAN FROM		40 THROUGH		41 CODE		42 OCCURRENCE SPAN FROM		43 THROUGH							
39										40 CODE		41 VALUE CODES AMOUNT		42 CODE		43 VALUE CODES AMOUNT															
a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z						
44 REV. CD.	45 DESCRIPTION			46 HCPCS / RATE / HIPS CODE			47 SERV. DATE		48 SERV. UNITS		49 TOTAL CHARGES		50 NON-COVERED CHARGES		51		52		53		54		55		56						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60		
PAGE	OF	CREATION DATE																													
60 PAYER NAME				61 HEALTH PLAN ID				62 REL. REG.		63 AGG. REG.		64 PRIOR PAYMENTS		65 EST. AMOUNT DUE		66 NR		67		68		69		70		71		72		73	
58 INSURED'S NAME				59 P.REL.		60 INSURED'S UNIQUE ID				61 GROUP NAME				62 INSURANCE GROUP NO.																	
63 TREATMENT AUTHORIZATION CODES						64 DOCUMENT CONTROL NUMBER						65 EMPLOYER NAME																			
66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95		
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 EQ	73	74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 QUAL	78 LAST	79 FIRST	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	
80 REMARKS	81CC a	82 b	83 c	84 d	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	

UB-04 CMS 1450

APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC
NATIONAL UNION OF
BENEFICIARIES
LIC#215257

Chapter 6 Maximum Reimbursement Allowances (MRA)

CPT Code	MRA		CPT Code	MRA		CPT Code	MRA
11760	\$793.80		29824	\$4,204.80		64475	\$968.40
14040	\$2,463.60		29825	\$4,290.00		64476	\$920.40
20525	\$2,416.06		29826	\$4,759.91		64479	\$1,549.20
20610	\$620.40		29827	\$5,280.00		64480	\$900.00
20670	\$2,160.00		29828	\$5,398.80		64483	\$1,092.00
20680	\$2,218.80		29846	\$4,122.00		64484	\$1,092.00
23120	\$3,420.00		29848	\$4,410.00		64490	\$1,092.00
23412	\$4,824.00		29875	\$4,004.40		64491	\$1,092.00
23430	\$3,322.80		29876	\$3,871.80		64492	\$1,059.90
23700	\$1,207.86		29877	\$3,900.00		64494	\$960.00
24342	\$3,510.00		29879	\$5,123.40		64495	\$960.00
24359	\$3,625.50		29880	\$3,673.80		64510	\$1,092.00
25000	\$2,374.33		29881	\$3,567.60		64520	\$1,092.00
25111	\$2,530.80		29888	\$5,775.00		64622	\$1,548.00
25115	\$2,153.15		43239	\$1,050.00		64623	\$1,036.20
25608	\$6,393.00		49505	\$3,313.20		64626	\$1,200.00
25609	\$5,093.40		49585	\$3,512.10		64627	\$900.00
26055	\$2,107.50		62264	\$1,727.40		64633	\$900.00
26145	\$1,896.60		62290	\$1,462.20		64635	\$1,200.00
26418	\$2,606.10		62310	\$999.00		64636	\$900.00
26445	\$2,834.35		62311	\$960.00		64702	\$1,309.90
26540	\$3,051.12		62319	\$1,092.00		64718	\$2,900.37
26615	\$3,000.60		63030	\$7,203.60		64721	\$2,382.00
26735	\$2,452.80		63650	\$5,595.00		72275	\$570.00
26765	\$2,230.20		63685	\$14,256.00		76000	\$720.00
27096	\$1,092.00		64415	\$852.00		76942	\$720.00
29806	\$5,226.00		64445	\$720.00		77003	\$288.00
29807	\$5,666.40		64447	\$630.00		0232T	\$876.30
29821	\$8,582.40		64450	\$480.00			
29822	\$3,960.00		64470	\$968.40			
29823	\$4,603.80		64472	\$954.60			

CPT ® copyright American Medical Association.

Chapter 7 Definitions

1. "Ambulatory Surgical Center" or "ASC" means a health care facility as defined in s. 395.002(3), F.S.
2. "Associated Disposable Instrumentation" means any single-use item that is surgically inserted into the body, to be removed in less than six weeks, to facilitate the implantation of a Surgical Implant, or any single use item specifically required for the purpose of giving effect or function to an item that is inserted into the body during a surgical procedure such as ports, single-use temporary pain pumps, external fixators and temporary neurostimulators shall be considered Associated Disposable Instrumentation. Associated Disposable Instrumentation does not include cannulas or catheters removed prior to discharge, suction equipment, surgical blades or drill bits, except those drill bits deemed necessary by the manufacturer for the implantation of the particular implant, surgical staples or sutures, and any form of drainage catheter or system. For the purpose of determining reimbursement according to this Manual, any requests for reimbursement of Associated Disposable Instrumentation must be reflected on the same acquisition invoice as the Surgical Implant(s).
3. "Authorization" means the approval given to a health care provider by the carrier, self-insured employer or entity representing the carrier or self-insured employer for the provision of specific medical services to an injured worker.
4. "Charge Master" means a comprehensive listing that documents the facility's charge for all of the goods and services for which the facility maintains a separate charge, regardless of payer type. The Charge Master shall be maintained and produced when requested for the purpose of verifying its usual charges pursuant to s. 440.13(12)(d), F.S.
5. "Division" means the Division of Workers' Compensation of the Department of Financial Services as defined in s.440.02(14),FS.
6. "Health Care Provider" means a provider as defined in s. 440.13 (1)(g), F.S.
7. "Maximum Reimbursement Allowance" or "MRA" means the specifically listed maximum dollar amount in the schedule adopted by the Three-Member Panel for reimbursement of medical service(s) rendered to an injured worker by a health care provider.
8. "Medically Necessary or Medical Necessity" means any medical service or medical supply which meets the definition of the terms according to s. 440.13(1)(k), F.S.
9. "Medical Record" means patient records maintained in accordance with the form and content required under Chapter 395, F.S.

Chapter 7 Definitions

10. "Medical Record Review" means a review of the medical record of the injured worker in order to verify the medical necessity of the services and care as well as the charges for a specific injured worker's bill.
11. "Physician" means a physician as defined in s. 440.13(1)(p), F.S.
12. "Surgical Implant(s)" means, for the purpose of determining reimbursement according to this Manual, any single-use item that is surgically inserted and deemed to be medically necessary by an authorized physician and which the physician does not specify to be removed in less than six weeks such as bone, cartilage, tendon or other anatomical material obtained from a source other than the patient; plates; screws; pins; internal fixators; joint replacements; anchors; permanent neurostimulators; and permanent pain pumps.

Chapter 8 Form DFS-F5-DWC-90 Completion Instructions

Form Completion Instructions Please follow the links below to obtain instructions required to complete the appropriate forms for billing carriers. When accessing the DWC web site, please click on Forms and go to Chapter 69L-7.

Form DFS-F5-DWC-90-B (UB-04) Completion Instructions may be obtained from the [DWC Web site](#) for dates of service on or after 07/08/2010.

Form DFS-F5-DWC-9- C Completion Instructions may be obtained from the [DWC Web site](#) for date(s) of service prior to 07/08/2010.

APPENDIX A		
Workers' Compensation Unique Procedure Codes		
FL Workers' Compensation Unique Procedure Code	FL Workers' Compensation Unique Description	MRA
99070 IM	Surgical Implant(s)	50% above acquisition invoice cost; amount certified or contract amount.
99070 DI	Associated Disposable Instrumentation used for Surgical Implant(s); must be included on the same acquisition invoice with the Surgical Implant(s).	20% above acquisition invoice cost; amount certified or contract amount.
99070 SH	Shipping and Handling costs for Surgical Implant(s) and Associated Disposable Instrumentation as listed on the acquisition invoice.	Actual cost on acquisition invoice; amount certified or contract price.

Note: Workers' Compensation unique procedure codes 99070 with their required modifiers are reimbursed pursuant to the policy for **Surgical Implant Reimbursement** in this Manual.