Florida Workers' Compensation

Reimbursement Manual for Ambulatory Surgical Centers

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

2011 Edition

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Chapter 1 Introduction and Overview

Changes to the Manual

All changes are subject to the Rulemaking procedures outlined in Chapter 120, Florida Statutes.

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 'Publications and Manuals' immediately proximal to the affected Manual on the DWC web site.

It is important that Ambulatory Surgical Centers (ASCs) and insurers 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 DWC E-Alert on the right side. 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

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 resource:

- The Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, 69L-7.602, 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 "Publications and Reimbursement Manuals" 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 s. 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 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 reimbursements to ASCs.

Insurer Responsibilities

An insurer 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 insurer under which claims are paid, adjusted and paid, disallowed, denied, or otherwise processed and submitted to the Division.

At the time of authorization for medical service(s), an insurer shall notify each ASC, in writing, of additional form completion requirement(s) or supporting documentation that is necessary for reimbursement determinations.

At the time of authorization for medical service(s), an insurer shall inform in-state and out-of-state health care providers of the specific reporting, billing and submission requirements of this rule and provide the specific address for submitting a reimbursement request.

Chapter 2 Program Requirements, continued

Prior Authorization of Services

Florida ASC facilities and out-of-state facilities must be authorized by the workers' compensation insurer 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 certified 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.

Chapter 2 Program Requirements, continued

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 insurer or its designated entity; and
- The name of the person authorizing the ASC services.

Insurer Responsibilities at Authorization

Insurers must comply with the statutory requirements in s. 440.13, F.S., to include responding to authorization requests timely and of ensuring that ASC facilities are eligible to receive reimbursement for the treatment being requested.

An insurer is responsible for meeting its obligations regardless of any business arrangements with any service company/TPA, submitter or any other entity acting on behalf of an insurer when processing or submitting claims under Chapter 440, F.S.

At the time of authorization for medical service(s), an insurer shall notify each health care provider in writing, of additional form completion requirements or supporting documents that are necessary for reimbursement determinations and provide the specific address for submitting a reimbursement request.

Fraud Statement

Any ASC who makes claims for services provided to the claims-handling entity on a recurring basis may make one signed attestation to the claims-handling entity as required by s. 440.105(7), F.S., which will satisfy the requirement for all claims submitted to the claims-handling entity for the calendar year in which the attestation is submitted. The attestation shall be personally signed by a corporate officer, principal, or other such person who has the authority to execute documents on behalf of the ASC.

Chapter 2 Program Requirements, continued

Materials Incorporated by Reference

The following materials are incorporated by reference for use in identifying descriptive codes and terms throughout this Manual. The use of the referenced codes and descriptions is required for reporting medical services and procedures provided to injured workers by ASCs.

The codes and descriptions used to report medical treatment to injured workers shall be the codes and descriptions listed in the reference documents below.

- Current Procedural Terminology, Professional Edition (CPT® 2010), Copyright American Medical Association, 2009;
- CPT Assistant®, Copyright American Medical Association;
- Healthcare Common Procedure Coding System (HCPCS Level II®), Copyright Ingenix, Inc.(American Medical Association) for dental D codes, other medical services and supply codes, 2010;
- The date-applicable Florida Medical Implementation EDI Guide (MEIG);
- The Physician ICD-9-CM-CM 2010, Volumes 1 & 2, International Classifications of Disease, 9th Revision, Clinical Modification, Copyright 2009,Ingenix, Inc.;
- The 2010 ICD-9-CM Professional for Hospitals, Volumes 1,2, and 3, International Classification of Diseases, 9th Revision, Clinical Modification, Copyright 2009, Ingenix, Inc.;
- The Official UB-04 Data Specifications Manual 2010®, (UB-04), July 2009, Copyright American Hospital Association;
- Form DFS-F5-DWC-90;
- Form DFS-F5-DWC-90-C Completion Instructions.

Chapter 2 Program Requirements, continued

Provider Use of Codes, Descriptions, and Modifiers

An ASC shall use the codes and descriptions, modifiers, guidelines, definitions and instructions of the referenced CPT®, ICD-9®, HCPCS® or Workers' Compensation unique codes and modifiers as specified in this Manual.

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

All diagnosis codes must be reported to the highest level of specificity according to the ICD-9® valid number of digits required for the diagnosis code; i.e. 4th and 5th digits where notation is made in the ICD-9 CM® Manual.

Insurer Use of Codes, Descriptions, and References

Insurers shall use the codes and descriptions, guidelines and instructions of the referenced CPT®, HCPCS®, ICD-9® or Florida Workers' Compensation Unique Codes and modifiers on the medical bill prior to making reimbursement decisions.

Charge Master and 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 an insurer 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.

An ASC shall produce copies of requested documents, or make the documents available for on-site review, within thirty (30) days of receipt of the written request from the Division, an insurer or its designee to conduct a review or audit.

Division Requests

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

Chapter 2 Program Requirements, continued

Exit Interview

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

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 insurer 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 provider received written notification from the employer or carrier as being a required component for reimbursement, when the services were authorized.

Failure of the provider to forward additional information, when requested by the employer/insurer 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 necessary 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.
Insurer Requests	An ASC shall, upon request, furnish an insurer or the insurer's attorney a copy of the injured worker's medical records and reports. An ASC, upon request, shall furnish the insurer or the insurer'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. Failure to forward the requested information shall result in administrative action pursuant to the provisions in s. 440.13, F.S.
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 insurer 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

ASC Payments

Provider Payment

All ASC payments are subject to the reimbursements pursuant to this Manual.

Note: See Chapter 5 for MRAs.

Reimbursement Generally

Reimbursement shall be made to an ASC provider after applying the appropriate reimbursements contained in this Manual.

For procedures listed in Chapter 5 of this Manual, the ASC shall be reimbursed either:

- The MRA in the reimbursement schedule; or
- The agreed upon contract price.

For procedures which are not listed in Chapter 5 of this Manual, the ASC shall be reimbursed either:

- Seventy percent (70%) of the ASC's billed charge for the first billed line item, or
- An agreed upon contract price.

Reimbursement for multiple procedures, bilateral, unilateral and terminated procedures shall be as further specified in this Manual.

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

Chapter 2 Program Requirements, continued

ASC Payments, continued

Components of a Procedure

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 when received and included on the acquisition invoice for the Surgical Implant(s), and shipping & handling costs.

Reimbursement Components

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

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

Surgical Implant Fee(s) are billed by the ASC and reimbursed to the ASC according to the guidelines for Surgical Implant(s) in this Manual.

Chapter 2 Program Requirements, continued

ASC Payments, continued

Description of 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 specifications outlined for Surgical Implants, Associated Disposable Instrumentation and shipping and handling in this Manual.

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., fiberoptic 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 or therapeutic items and services: many ASCs perform simple test(s) just before surgery, such as urinalysis, blood hemoglobin or hematocrit, or blood glucose which are included in the ASC facility charges and are considered to be facility services;
- Administrative, recordkeeping, and housekeeping items (i.e., administrative functions necessary to run the facility, such as scheduling, cleaning, linens, and utilities, leases or rent);
- Mortgage, lease or rent payment(s) on the facility itself; lease or rent payments on any equipment within the ASC,
- Blood, blood plasma or platelets: ASC procedures are limited to those not expected to result in extensive blood loss, but in some cases, blood or blood products are required; and
- Materials for anesthesia including the anesthesia itself, and any materials, whether disposable or reusable, necessary for its administration.

Chapter 2 Program Requirements, continued

ASC Payments, continued

Non-ASC Facility Services

Non-ASC facility services include a number of items and services furnished in an ASC that can be reimbursed under other Florida Workers' Compensation Manuals which 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 **the DWC web site** for the other Reimbursement Manuals that provide policy, reimbursement, coverage and guidelines.

Note: These services are not reimbursable to an ASC facility.

Physician or Other Recognized Health Care Practitioner Services

The insurer 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-7.602, F.A.C. and Rule 69L-7.020, F.A.C. and are not reimbursable to an ASC facility.

Chapter 3 Reimbursement Policies and Guidelines

Determining Reimbursement Amounts

Reimbursement for Surgical Services

For procedures listed in Chapter 5 of this Manual, the ASC shall be reimbursed either:

- The MRA, or
- The agreed upon contract price.

For procedures which are not listed in Chapter 5 of this Manual, the ASC shall be reimbursed:

- Seventy percent (70%) of the ASC's billed charge; or
- The agreed upon contract price.

Note: See other Labels in this Chapter for variances from this payment method.

Pathology/Laboratory Services

Preadmission 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.

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. However, the ASC shall be reimbursed for procedure code 36415 for the collection of a blood specimen that must be conveyed to an independent laboratory.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Radiology/Imaging Services

Preadmission 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 admission are reimbursed separately at either:

- Seventy percent (70%) 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 Fluoroscopy is limited to one unit of service per spinal region (cervical, thoracic, and lumbar); not per level.

Surgical Implant(s) 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 Surgical 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;
- The ASC shall be reimbursed for shipping and handling at the actual cost to the provider 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. See **Request for Surgical Implant(s) Reimbursement** later in this chapter.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Billing for Surgical Implant(s), Associated Disposable Instrumentation, Shipping and Handling

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

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

Shipping and handling shall be billed using the Workers' Compensation unique procedure and modifier code: 99070 SH.

Note: Instructions contained in 69L-7.602(4)(b)6, F.A.C, the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, 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) C claim form. The Workers' Compensation unique procedure codes and their required modifiers stated above shall be billed on separate lines in Form Locator 44.

Determining Surgical Implant(s) 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.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Request for Surgical Implant(s) Reimbursement

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

- Certify in writing on the DWC-90 billing form, in Form Locator 80, that 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 DWC-90 claim form in the Form Locator 80 labeled "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 insurer along with the acquisition invoice(s) that substantiate the cost of the items(s) billed.

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 shall not be reimbursed.

Note: See **Certification of Surgical Implant(s), Associated Disposable Instrumentation, and Shipping and Handling Reimbursement Amount** later in this chapter.

Note: Instructions contained in 69L-7.602(4)(b)6, F.A.C, the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, 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) C claim form. The Workers' Compensation unique procedure codes and their required modifiers stated above shall be billed on separate lines in Form Locator 44.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Verification of Surgical Implant(s) Costs and Charges

The ASC certification of the amount requested for reimbursement, whether in writing, by prior written agreement with the insurer, or by the billing form, and the ASC compliance with the billing requirements in this Manual and Rule 69L-7.602, F.A.C., (The Workers' Compensation Medical Services Billing, Filing and Reporting Rule) shall be subject to verification through audit and medical record review.

Upon request by the Division, an insurer 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 elsewhere by mutual agreement, within thirty (30) days of the request.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Certification of Surgical Implant(s), Associated Disposable Instrumentation, Shipping and Handling Reimbursement Amount

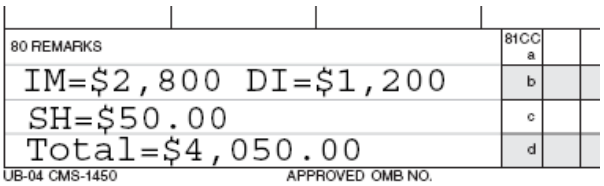
Certification of a medical bill that the amount requested for reimbursement for the Surgical Implant(s) billed under Revenue Code 278 is fifty percent (50%) over the acquisition invoice cost, and Associated Disposable Instrumentation is twenty percent (20%) over the acquisition invoice cost. The documentation 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 provider. Certification as specified in this Chapter may 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 insurer 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 of 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 labeled 'Remarks'.

The ASC shall separately list the abbreviation of each category in the Form Locator 80 of the DWC-90 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 Implant(s) (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:



Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Multiple Surgical Procedures

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

- The primary, or most clinically significant procedure, shall be reported first without appending modifier 51.
- Each additional surgical procedure code shall be listed separately and reported by appending modifier 51.

Multiple Surgical Procedure Reimbursement Amount

To find the reimbursable amount on any additional surgical procedure(s), identify the following four (4) values:

1. The reimbursable amount of the billed primary procedure code pursuant to the policy in this Manual, and

2. 50% of the billed charge for the additional surgical procedure code,

3. The MRA of the billed additional surgical procedure code from the Fee Schedule in Section V, if any, and

4. The contracted reimbursement amount, if applicable.

If there is a contracted reimbursement amount, reimburse the contracted amount.

Otherwise, reimbursement is the lesser value of either item 2 or item3, not to exceed the value identified in item 1.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Bilateral Procedures Listed in CPT®

Surgical procedures that are listed in CPT©® as bilateral are exempt from the modifier 50 billing requirement.

Bill with the appropriate procedure code on one line of the claim form without appending a modifier 50.

Note: When the bilateral procedure code is not the primary procedure code on the medical bill, the reimbursement for the bilateral procedure code is subject to **Multiple Surgical Procedure Reimbursement Amounts**.

Reimbursement for Bilateral Procedures Listed as Bilateral in CPT®

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

For bilateral surgical procedure codes listed in Chapter 5, the ASC shall be reimbursed either:

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

For bilateral surgical procedure codes not listed in Chapter 5, the ASC shall be reimbursed either:

1. Seventy percent (70%) of billed charges for the primary procedure code; or
2. The agreed upon contract price.

Note: When the bilateral procedure code is not the primary procedure code on the medical bill, the reimbursement for the bilateral procedure code is subject to **Multiple Surgical Procedure Reimbursement Amounts.**

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Billing Bilateral Procedures Not Listed in CPT®

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 in CPT®

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

For primary surgical procedures listed in Chapter 5, the ASC shall be reimbursed either:

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

For primary bilateral surgical procedures not listed in Chapter 5, the ASC shall be reimbursed either:

1. Seventy percent (70%) of billed charges; or
2. The agreed upon contract price.

Note: When the bilateral procedure code is not the primary surgical procedure code on the medical bill, the reimbursement for the bilateral procedure code is subject to **Multiple Surgical Procedure Reimbursement Amount** guidelines.

Billing Bilateral Procedures Performed with Other Surgical Services

If bilateral surgical procedures are performed during the same operative session with other surgical services:

- Bill the primary surgical procedure code on the first line using no modifier 51.
- Bill the additional surgical procedure code(s) using modifier 51 to indicate multiple procedures performed during the same operative session.
- Bill the bilateral procedure using modifier 50 in the first modifier position, where appropriate. Then bill modifier 51 in the second modifier position.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Reimbursement for Bilateral Procedures Performed with Other Surgery

Reimbursement for bilateral procedures performed with other surgical procedures during the same operative session shall be reimbursed according to the guidelines for **Multiple Surgical Procedures Reimbursement Amount** as identified earlier in this chapter.

Unilateral Services

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

The reimbursement amount shall be the contractual amount if the contract was written for a bilateral procedure description that is being performed unilaterally. If the agreed upon contract amount was for a bilateral procedure that was contracted to be performed bilaterally, but the procedure was performed unilaterally, reimbursement shall be fifty percent (50%) of the contracted amount.

If there is no contracted amount, reimburse fifty percent (50%) of the MRA, if the procedure code is listed in Chapter 5, or fifty percent (50%) of seventy percent (70%) of billed charges, if the procedure code is not listed in Chapter 5.

Note: If the procedure code is not the primary procedure code, the amount determined pursuant to this section shall be used under **Multiple Surgical Procedure Reimbursement Amount**, earlier in this Chapter, as the amount under items 3, or 4, as applicable therein, unless the procedure code is not listed in Chapter 5, in which case, fifty percent (50%) of the amount determined pursuant to this section shall be used under item 2, therein.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, 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;
3. Supplies actually provided; and
4. CPT® code(s) for the procedure(s) had the scheduled surgery been performed.

Modifier 73 or 74 must be added to the procedure codes actually performed to identify the circumstances under which the services were terminated as described below.

Reimbursement for Terminated Procedures

Terminated Procedures shall be reimbursed as follows:

1. No reimbursement shall be made for a procedure that is terminated either for medical or non-medical reasons before the pre-operative procedures are initiated by staff.
2. Reimbursement shall be fifty percent (50%) of the amount allowed for the procedure(s) 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 amount allowed for the procedure(s) 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.
4. Multiple surgery pricing reduction rules do not apply to terminated surgeries.

Chapter 3 Reimbursement Policies and Guidelines, continued

Determining Reimbursement Amounts, continued

Out-of-State Facility

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

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

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

- The reimbursement amount allowed by the Florida schedule; or
- The reimbursement amount of the state in which the service(s) are rendered.

Chapter 4 Disallowed, Denied and Disputed Charges

Disallowance and Adjustment of Itemized Charges

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

- 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.

Timely Payment and Notice of Adjustment, Disallowance or Denial

Notwithstanding the insurer's right to disallow or adjust charges, the insurer shall comply with the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, 69L-7.602, 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 insurer denies, disallows or adjusts payment for ASC charges, in accordance with the time limitation and coding requirements established by Rule 69L-7.602, F.A.C., and s. 440.20(2)(b), F.S., the insurer 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

Upon receipt of an EOBR from the insurer for less than the expected amount, the ASC may elect to contest the disallowance or adjustment of payment under s. 440.13(7), F.S. and Rule Chapter 69L-31. The election to contest the disallowance or adjustment of payment under s. 440.13(7), F.S., must be made by the ASC within thirty (30) days of receipt of the notice of disallowance or adjustment of payment.

Chapter 5 Maximum Reimbursement Allowances

	CPT®	MRA
Codes with MRA's	20680	$1,810
	26055	$1,906
	27096	$ 980
	29824	$3,266
	29826	$3,276
	29827	$3,539
	29877	$3,150
	29880	$3,474
	29881	$3,150
	29888	$5,110
	62290	$1,347
	62310	$ 980
	62311	$1,065
	62319	$1,402
	64490	$1,049
	64491	$ 759
	64492	$ 759
	64493	$ 932
	64494	$ 791
	64495	$ 791
	64479	$1,281
	64483	$1,147
	64484	$ 896
	64510	$ 844
	64520	$1,051
	64622	$1,597
	64623	$1,050
	64626	$1,264
	64721	$2,159

Workers' Compensation Unique Codes

FL Workers' Compensation Unique Procedure Code	FL Workers' Compensation Unique Description	MRA
99070 IM	Surgical Implant(s)	50% above acquisition invoice cost; contract price or amount certified
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; contract price or amount certified
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; contract price or amount certified

Note: Workers' Compensation unique codes 99070 with their required modifiers are not subject to the Multiple Surgical Procedure Reimbursement Amounts.

Chapter 6 Billing Instructions and Forms

Administrative Purpose

The administrative purpose of this Chapter is to provide billing instructions to ASC providers and insurers for services provided to injured workers. This Chapter also provides billing Forms and references to obtain the Forms, Form Completion Instructions and special billing instructions.

Bill Submission/Filing and Reporting Requirements

Provider 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 insurer.

Additional Information Requested by Insurer

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

Bill Completion

Form DFS-F5-DWC-90 (UB-04) shall be legibly and accurately completed by all ASCs, regardless of reimbursement method.

An insurer can require an ASC to complete additional data elements that are not required by the Division on Form DFS-F5-DWC-90 if such data elements are necessary for the adjudication and proper reimbursement of services reported if requested by the insurer at the time of authorization.

Chapter 6 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-C 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 to the insurer, service company/TPA or any entity acting on behalf of the insurer, 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 insurer, service company/TPA or any entity acting on behalf of the insurer, provided the insurer agrees.
Bill Corrections	ASCs are responsible for correcting and resubmitting any billing forms returned by the insurer, service company/TPA or any entity acting on behalf of the insurer pursuant to Rule 69L-7.602, 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 6 Billing Instructions and Forms, continued

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

Official Guidelines for Billing

All ASC providers shall complete the Form DFS-F5-DWC-90 (UB-04) according to the Form Locator attributes and Notes, pursuant to the National Uniform Billing Committee Official UB-04 Data Specifications Manual 2010, July 2009.

Form DFS-F5-DWC-90-C is the set of instructions for completing the form. Follow this link below to access the form completion instructions:
Form DFS-F5-DWC-90-C.

Revenue Codes for Billing

An ASC shall report Revenue Codes in Form Locator 42 in addition to HCPCS® codes or Workers Compensation unique 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 HCPCS® Level I or Level II code in Form Locator 44. Modifiers shall be used, when appropriate.

Note: HCPCS® codes or Workers' Compensation unique codes are required in Form Locator 44 unless the Revenue Code billed is listed on the Division's list of Revenue Codes that do not require a HCPCS® code. This list is available at the following link:

Please click this link below to view the document:
ASC Revenue Code Programming Document

Chapter 6 Billing Instructions and Forms, continued

Surgical Implants

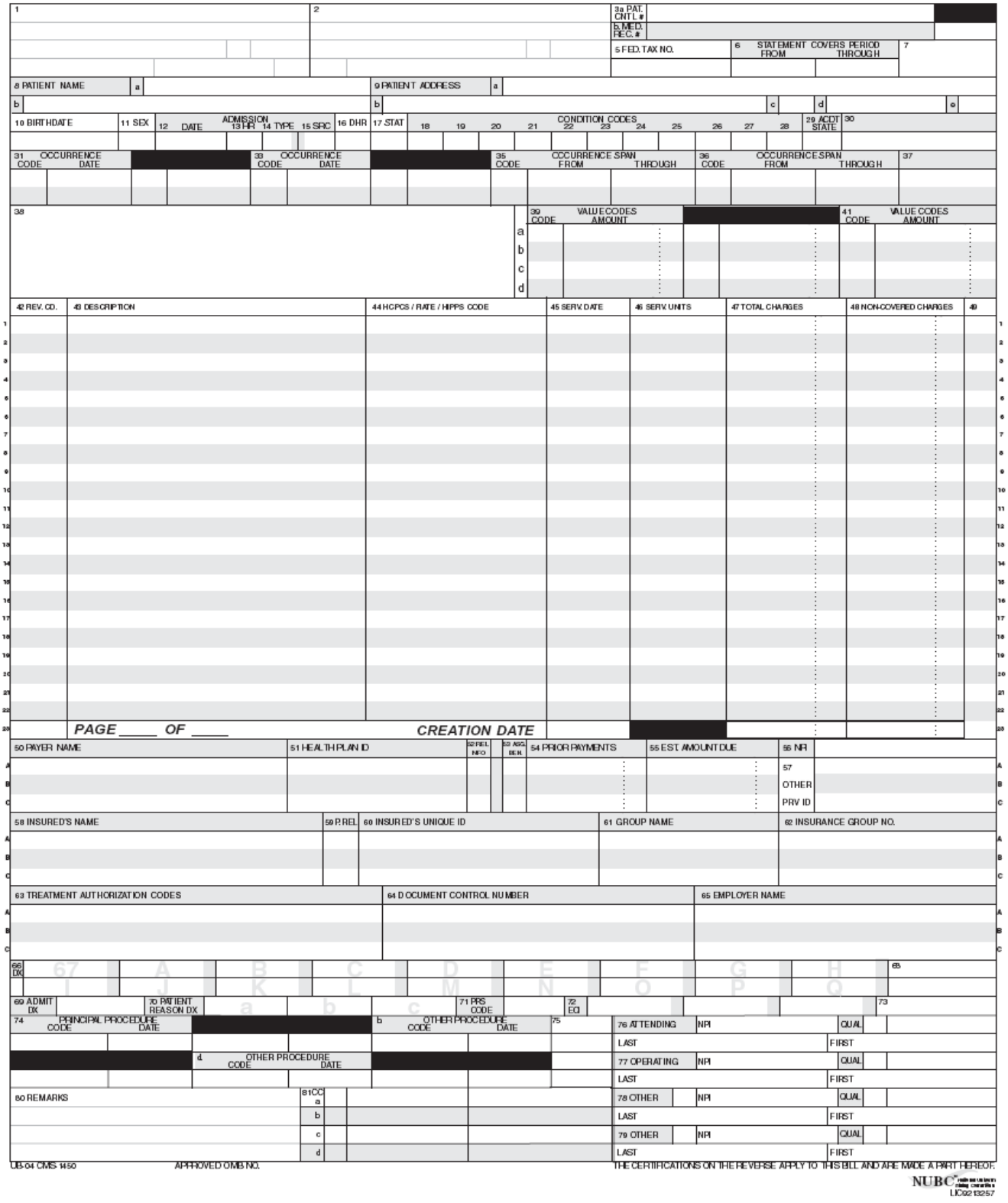
Surgical Implants, Associated Disposable Instrumentation and shipping and handling must be billed under Revenue Code 278 in Form Locator 42. The following Workers' Compensation unique code(s) with required modifiers must be billed in Form Locator 44 for proper reimbursement:

For Surgical Implants – 99070 IM
For Associated Disposable Instrumentation – 99070 DI
For shipping and handling – 99070 SH

Note: 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).

Chapter 6 Billing Instructions and Forms, continued

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



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 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 a particular implant, surgical staples, and any form of drainage catheter or drainage system. For the purpose of determining reimbursement according to this Manual, any requests for reimbursement of Associated Disposable Instrumentation must be reflected on the acquisition invoice for the Surgical Implant(s).
3. "Authorization" means the approval given to a health care provider by the insurer, self-insured employer or entity representing the insurer 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), F.S.
6. "Health Care Provider" means a provider as defined in s. 440.13 (1), 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)(l), F.S.
9. "Medical Record" means patient records maintained in accordance with the form and content required under Chapter 395, F.S.
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)(q), 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 Forms and Completion Instructions

Forms and Completion Instructions

Image of the Form DFS-F5-DWC-90 (UB-04) may be viewed at the following web site:
http://www.cms.hhs.gov/MLNProducts/downloads/ub04_fact_sheet.pdf

Form DFS-F5-DWC-90-C Completion Instructions may be obtained from the **DWC Web site** for dates of service on or after 07/08/2010.