Florida Workers' Compensation
Reimbursement Manual for Ambulatory Surgical Centers, 2020 Edition

Notice of Proposed Rule Changes
Rule 69L-7.100, F.A.C.
Hearing Date: 08/30/2022

SUMMARY OF CHANGES PROPOSED RULE 69L-7.100, F.A.C.

RULE REVISION OVERVIEW:

Proposed Draft Rule 69L-7.100, Florida Administrative Code (F.A.C.), incorporates the following updates to the Florida Division of Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2020 Edition; changes are made in punctuation, grammar, internet web site links, and section/paragraph titles for clarity and consistency throughout the manual; changes have been made in the sections entitled "Program Requirements", and "Medical Records" to make the current policy language consistent with the Florida Division of Workers' Compensation Health Care Provider Reimbursement Manual and the Florida Division of Workers' Compensation Reimbursement Manual for Hospitals; the CPT copyright statement was stricken from the policy section and placed in the page footer; references to the word "will" and "shall" are stricken and replaced with the word "must"; changes in policy language are made for clarification; the reimbursement methodology for surgical procedures has changed; the surgical implant reimbursement percentage has changed; documentation requirements for surgical implants and associated disposable instrumentation have been updated; the term "manufacturer's" has been stricken from "manufacturer's acquisition invoice"; certification of surgical implant reimbursement is stricken; and the schedule of maximum reimbursement allowances have been updated. The reimbursement manual also incorporates new billing instructions and a new schedule of reimbursement allowances for CPT codes not listed in Appendix A.

RULE HISTORY:

Rule 69L-7.100, F.A.C., the Florida Division of Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2015 Edition (Effective January 1, 2016)

Rule 69L-7.100, F.A.C., Florida Division of Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2011 Edition (Effective November 13, 2011)

PROPOSED CHANGES:

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3	----------	The five-character codes included in the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 202018 Edition, are obtained from the Current Procedural Terminology (CPT), copyright 20197 by the *American Medical Association* (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. The responsibility for the content of the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 202018 Edition, is with the Department of Financial Services DFS and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences of liability attributable of related to any use; nonuse or interpretation of information contained in the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 202018 Edition, fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no *liability for data contained or not contained herein*. Any use of CPT outside of the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 202018 Edition, should refer to the CPT, which contains the complete and most current code listings and descriptive terms. CPT is a registered trademark of *the American Medical Association.*

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4	**Changes to the Manual**	It is important that Ambulatory Surgical Centers (ASCs) and carriers read the updated material in the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers (Manual). Both parties have a responsibility for performing certain ~~specific~~ duties when billing, reporting, or reimbursing Workers' Compensation medical bills for treatment of ~~services rendered to~~ injured workers. ~~Reimbursement Manuals are available under the "Reimbursement Manuals" section on the Division of Worker's Compensation (DWC) website at https://www.myfloridacfo.com/Division/WC.~~
4	**E-Alert System**	The Division of Workers' Compensation (DWC) has an electronic alert (E~~e~~-Alert) system to notify subscribers of news impacting the Workers' Compensation industry and dates of upcoming public meetings and workshops. To subscribe to the E~~e~~-Alerts, please go to the DWC website, https://www.myfloridacfo.com/Division/WC/. Look for the "Register" link near the bottom of the page. Once completed, you will receive E~~e~~-Alerts whenever they are provided by the Division ~~DWC~~. **DWC E-alerts** To receive important Division notices, register for our email list. Register
~~4~~	~~**Background**~~	~~There are three different Workers' Compensation Reimbursement 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.;~~ • ~~Florida Workers' Compensation Reimbursement Manual for Hospitals, Rule 69L-7.501, F.A.C.~~
~~4~~	~~**Other Applicable Rules**~~	~~In addition to this Manual, Rule 69L-7.100, F.A.C., also recognizes the following resource: The DWC Medical Reimbursement and Utilization Review, Rule Chapter 69L-7, F.A.C.~~
~~4~~	**Legal Authority**	The following statute~~s~~ and rule chapter govern W~~w~~orkers' C~~c~~ompensation billing, filing, and reporting in Florida: • Chapter 440, Florida Statutes (F.S.) • Rule Chapter 69L-7, Florida Administrative Code (F.A.C.) The specific Florida Statute~~s~~ and Florida Administrative Code for each service are cited for reference ~~in each specific manual~~, where appropriate.
5	**Purpose**	The Manual contains the schedule of Maximum Reimbursement Allowances (MRAs) approved by the Three Member Panel for ~~surgical~~ reimbursing ~~procedures performed in the~~ Ambulatory Surgical Centers (ASCs) ~~ASC 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 section 440.02, F.S., and may also refer to a service company, T~~t~~hird P~~p~~arty A~~a~~dministrator (TPA), or any other entity acting on behalf of a carrier for the purposes of administering W~~w~~orkers' C~~c~~ompensation benefits for its insured(s). The policies, procedures, principles, and standards in this Manual are in addition to the requirements established by Rule Chapter 69L-7, F.A.C.

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5	**Fraud Statement**	Any ASC that makes claims for services provided to the claims-handling entity on a recurring basis may make one personally signed attestation to the claims-handling entity as required by section 440.105(7), F.S., which must satisfy the requirement for all claims submitted to the claims-handling entity for the calendar year in which the signed attestation is submitted. "Any person who, knowingly and with intent to injure, defraud, or deceive any employer or worker, insurance company, or self-insured program, files a statement of medical bill containing any false or misleading information commits insurance fraud, punishable as provided in section 817.234, F.S."
5	**Carrier Responsibilities**	A carrier is responsible for meeting its obligations ~~the~~ under this Manual ~~will~~ 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, or denied~~, or~~ to ASCs. ~~otherwise processed and submitted to the Division.~~ Carriers must inform ASCs of the specific reporting, billing, and submission requirements of Rule Chapter 69L-7, F.A.C., and any terms of settlement or apportionment, when known, and provide the specific address for submitting the ASC bill. Carriers must comply with the requirements of Rule Chapter 69L-7, F.A.C., which includes the reporting requirements of the Florida Medical EDI Implementation Guide (MEIG). ~~At the time of authorization for medical service(s), a carrier must notify each ASC, in writing, of additional form completion requirements or supporting documents that are necessary for reimbursement, inform the ASC of any apportionment, if known, and provide the specific address for submitting a reimbursement request.~~ Pursuant to paragraph 440.13(3)(e), F.S., carriers must have procedures for receiving, reviewing, documenting and responding to requests for authorization. Such procedures must be made available upon request to the Department.
5	**ASC Responsibilities**	An ASC is required to meet their obligations under this Manual, regardless of any business arrangement with any entity under which medical bills are prepared, processed, or submitted to the carrier.
5	**Prior Authorization of Services**	Both Florida ASC facilities and out-of-state facilities must have ~~be~~ authorizationed by the Wworkers' Ccompensation 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. At the time of authorization for medical services, a carrier must inform out-of-state ASCs of the specific reporting, billing, and submission requirements of this Manual and provide the specific address for submitting a medical bill. Exceptions to prior authorization are: • Federal facilities; • Emergency services and care, defined in section 395.002, F.S.; or • A health care provider referral for emergency treatment resulting from emergency services.

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5	**Prior Authorization of Services (continued)**	Medical authorization is an integral component of an efficient and self-executing Workers' Compensation system. The request for authorization and the timely decision to authorize or not authorize has a direct impact on the injured worker's medical care and treatment, the length of time the injured worker is out of work, whether the injured worker hires an attorney, ASC participation in the Workers' Compensation system, the cost of the claim, and the number of medical reimbursement disputes. Therefore, it is imperative the ASC clearly and comprehensively communicates to the insurance carrier the requested treatment and for the insurance carrier to ask clarifying questions or request additional documentation to facilitate authorization.
6	**Provider Use of Codes, Descriptions, and Modifiers**	All~~n~~ ASCs must use the codes, descriptions, modifiers, guidelines, definitions, and instructions of the incorporated reference materials, as specified in Rule 69L-7.100, F.A.C., and the following completion instructions incorporated by reference in Rule Chapter 69L-7, F.A.C.: • ~~Form DFS-F5-DWC-9-C, Completion Instructions for Ambulatory Surgical Centers, Rev. 01/01/2015 (only for dates of service prior to 07/08/2010); or~~ Form DFS-F5-DWC-90-B (UB-04), Completion Instructions for Ambulatory Surgical Centers, Rev. 12/08/2015 (only for dates of service on and ~~or~~ after 07/08/2010). All diagnosis codes must be reported to their highest level of specificity according to the diagnosis code and descriptions using the valid number of digits, i.e., seven (7) digits where noted in the ~~ICD-~~ICD-10-CM® Manual.
6	**Billing New Procedure Codes Not Listed in the Fee Schedule**	In the event that a new CPT® code is created in the CPT® manuals released subsequent to the applicable manual incorporated by reference in rule, the ASC may bill the newly created CPT® code. Examples include: • Services or procedures not described in the incorporated CPT® manual requiring the use of an unlisted procedure code for billing; and • CPT codes with a substantial description change or newly adopted codes in the CPT manual published subsequent to this Manual
6	**Carrier Use of Codes, Descriptions, and References**	Carriers must use the codes, descriptions, modifiers, ~~policies~~, guidelines, definitions, and instructions of the incorporated reference material as specified in Rule 69L-7.100, F.A.C., prior to making reimbursement decisions.
~~6~~	~~**Division Requests**~~	~~An ASC will provide medical record(s) and relevant portions of the Charge Master(s) to the Division upon request without charge.~~
~~6~~	~~**Time Frames**~~	~~Neither a request nor completion of, an on-site record review or an audit will toll the time frame for payment of a medical claim or petitioning the Division for resolution of a reimbursement dispute pursuant to sections 440.20(2)(b), F.S., and 440.13(7), F.S., respectively.~~

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8	**Billing ~~Disclosure~~ to Carriers**	~~At a minimum,~~ When requested by the carrier, it is the responsibility of the ASC to furnish, without charge, the following documentation ~~to the carrier with the ASC bill~~: • An operative or procedural report when a ~~surgical~~ procedure is performed; • ~~Manufacturer's~~ Aacquisition invoices for Surgical Implant(s), Associated Disposable Instrumentation, and Shipping & Handling~~, when Surgical Implants and their associated costs are not certified pursuant to the policy~~; • The surgical implant log and documentation of the Associated Disposable Instrumentation utilized for implantation ~~are~~ required for all surgical procedures involving implants~~, whether the reimbursement to the ASC is by manufacturer's acquisition invoice cost or by ASC certification~~; and • ~~Any~~ Ccopies of any additional medical records. ~~required by the employer or carrier, provided the ASC received written notification from the employer or carrier of this being a required component for reimbursement when the services were authorized.~~ Failure of the ASC to submit documentation requested by the carrier ~~forward additional information, when requested by the employer/carrier~~ ~~at the time of authorization,~~ may result in the billed service(s) being disallowed, adjusted, or denied for payment. ~~until sufficient documentation is provided to render the determination.~~
~~8~~	~~**Mandatory Disclosure**~~	~~Unless otherwise prohibited by law, and subject to the confidentiality requirements of state and federal law(s), upon request of the Division, Office of Judges of Compensation Claims, injured worker, employer, or carrier, ASCs must produce any and all medical records, reports, and information regarding an injured worker relevant to the particular injury or illness for which compensability has been accepted or for which it is necessary to determine compensability.~~
~~8~~	~~**Disclosure to Injured Workers, Employers, and Carriers**~~	~~An ASC must, 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 copies of medical reports must be made to an ASC when requested by the injured worker or the injured worker's representative at no more than $0.50 per page.~~ ~~An ASC must, upon written request, furnish the injured worker or the injured worker's attorney non-written medical records.~~ ~~Reimbursement will 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.~~ ~~An ASC must provide, upon request, a copy of the injured worker's medical records and reports regarding the work-related injury to the carrier or the carrier's attorney.~~ ~~An ASC must provide, upon request, non-written medical records to the carrier or the carrier's attorney.~~

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8	**Copying Charges for Medical Records**	Copying charges for medical records are paid pursuant to ~~An injured worker or injured worker's attorney requesting copies of medical records must reimburse the ASC for copying charges according to~~ paragraph ~~section~~ 440.13(4)(b), F.S.~~, and Rule Chapter 69L-7, F.A.C., and the ASC may charge no more than $0.50 per page for copying the records and the ASCs actual direct costs for X rays, microfilm, or other non-paper records.~~ ~~No other copy charges or search charges may be charged to the injured worker or the injured worker's attorney as part of the services provided to the injured worker by the ASC.~~ ~~A carrier, employer, or authorized representative requesting copies of medical records must reimburse the ASC for copying charges according to section 395.3025, F.S.~~
8	**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 determined.~~
8	**Division or Judge of Compensation Claims Requests**	An ASC must provide, upon request, medical records and reports to the Division or a Judge of Compensation Claims without charge.
9	**ASC Services and 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 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 the cost of the operating room and all staff); and • **Surgical Implant Fee(s)**: The cost of the Surgical Implant(s), which includes the ~~manufacturer's~~ acquisition invoice cost of the Surgical Implant(s), the Associated Disposable Instrumentation required for implantation of the device ~~only when included on the same manufacturer's acquisition invoice for the Surgical Implant(s)~~, and Shipping & Handling.
9	**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 only to the ASC according to the policies for Surgical Implant(s) in this Manual.

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10	**Non-ASC Facility Services**	Non-ASC facility services includes a number of items and services furnished in an ASC that are ~~will be~~ reimbursed under other Florida Workers' Compensation Reimbursement Manuals and are not ~~billed by or~~ reimbursed to an ASC facility. The following are examples of non-ASC facility services that must be billed and reimbursed to other ~~those~~ health care providers under the applicable ~~other~~ Florida Workers' Compensation Reimbursement Manual policies and guidelines. These services are not reimbursable to an ASC facility: • ~~Physician and other health care practitioner services.~~ The carrier must not reimburse an ASC for any physician or other health care practitioner services when billed by the ASC on the ASC billing form. Proper billing and reimbursement of physician or other health care practitioner services rendered in any location, including inside an ASC, must be in accordance with the requirements of Rule Chapter 69L-7, F.A.C.; • Sale, lease, or rental of durable medical equipment for ASC patients ~~to~~ for use at home; • Services furnished by an independent laboratory, independent radiology, or other diagnostic testing facility; and • Hospital-based Ambulance services. **Note**: Please refer to DWC's website for other Reimbursement Manuals (located under the link for "Reimbursement Manuals") that provide policy, reimbursement, coverage, and guidelines.
11	**Reimbursement for Surgical Services**	For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price; • The MRA listed in Appendix A; or • If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B. ~~For each billed CPT® code listed in this Manual, the ASC will be reimbursed through either:~~ ~~• The MRA if listed in this Manual; or~~ ~~• The agreed upon contract price.~~ ~~For each CPT® code not listed in this Manual, the ASC will be reimbursed:~~ ~~• Sixty percent (60%) of the ASC's billed charge; or~~ ~~• The agreed upon contract price.~~ ~~If the CPT® code is identified as an unlisted procedure or service in the CPT® manual, the CPT® code will be priced by the carrier as By Report.~~ Reimbursement for Surgical Implant(s), Terminated Procedures, and Bilateral Procedures Performed Unilaterally must be as further specified in this Manual. ~~**Note:** See **Definitions** in this Manual for the definition of By Report.~~

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~~11~~	~~**Unlisted Procedure or Service Paid By Report**~~	~~Reimbursement for an unlisted procedure or service, as defined in the CPT® manual, will be determined by the carrier.~~ ~~Payment will be based on the ASC's documentation submitted to the carrier containing information on the complete description of the service(s) or procedure(s) performed and the technical component (TC) of facility equipment provided.~~ ~~Carriers may:~~ ~~• Determine reimbursement by comparing the service or procedure with clinically similar procedure code(s) found in the appropriate CPT® manual;~~ ~~• Make reimbursement decisions based on the ASC's documentation, medical bills, comparison data, services provided, equipment provided, and peer physician recommendations; and~~ ~~• Reimburse all work-related and medically necessary services provided in a documented medical or dental emergency.~~ ~~Reimbursement for Surgical Implant(s), Terminated Procedures, and Bilateral Procedures Performed Unilaterally will 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.~~
11	**Pathology/Laboratory Services**	Pathology or laboratory services provided by an Independent Clinical Laboratory must be billed by and reimbursed directly to the clinical laboratory provider according to the fee schedule in Rule 69L-7.020, F.A.C. ~~The ASC must 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, must be reimbursed ~~in accordance with the fee schedule established for non-hospital providers in Rule 69L-7.020, F.A.C.;~~ • According to an agreed upon contract price; or • The MRA in accordance with the fee schedule established for non-hospital providers in Rule 69L-7.020, F.A.C.
11	**Radiology/Imaging Services Prior to Admission**	Pre-admission radiology services, when required by the physician and performed by the ASC on a date other than the date of surgery, must be reimbursed ~~in accordance with the fee schedule established for non-hospital providers in Rule 69L-7.020, F.A.C. :~~ • According to an agreed upon contract price; or • The MRA in accordance with the fee schedule established for non-hospital providers in Rule 69L-7.020, F.A.C.

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11	**Radiology/Imaging Services Performed on the Day of Surgery**	Radiology/imaging procedures that are performed by the ASC on the day of the surgery are reimbursed separately. For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price; • The MRA listed in Appendix A; or • If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B. ~~For each billed CPT® code listed in this Manual, the ASC will be reimbursed through either:~~ ~~• The MRA if listed in this Manual; or~~ ~~• The agreed upon contract price.~~ ~~For each billed CPT® code not listed in this Manual, the ASC will be reimbursed:~~ ~~• Sixty percent (60%) of billed charges; or~~ ~~• The agreed upon contract price.~~ ~~If the CPT® code is identified as an unlisted procedure or service in the CPT® manual, the CPT® code will be priced by the carrier as By Report.~~ Radiology or Imaging services must ~~will~~ 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.
11	**Billing for Surgical Implant(s) and Associated Disposable Instrumentation**	Surgical Implant(s) must only be billed using Revenue Code 0278 and the Workers' Compensation Unique Procedure Code and Modifier Code 99070 IM. Associated Disposable Instrumentation required for implantation of the Surgical Implant(s) must only be billed using Revenue Code 0278 and the Workers' Compensation Unique Procedure Code and Modifier Code 99070 DI. Shipping and Handling must only be billed using Revenue Code 0278 and the Workers' Compensation Unique Procedure Code and Modifier Code 99070 SH. The Workers' Compensation Unique Procedure Code and Modifier Code combinations stated above must be billed on separate lines in Form Locator 44. **Note**: Instructions contained in this Manual ~~Rule Chapter 69L-7, F.A.C.,~~ must be followed ~~used~~ to bill Surgical Implant(s), Associated Disposable Instrumentation, and Shipping and Handling on ~~Form Locator 42 of~~ Form DFS-F5-DWC-90/UB-04 CMS-1450 (DWC-90). ~~No reimbursement is made for sales tax.~~ In order to receive reimbursement for Surgical Implant(s) and associated costs, the ASC must: • Submit to the carrier a copy of the implant log, found in the operative records, and documentation of the Associated Disposable Instrumentation used for implantation; and • Submit acquisition invoice(s) for the Surgical Implants and Associated Disposable Instrumentation documenting the unit price, the quantity, and the total costs of each item utilized for implantation; and • Submit detailed calculations by summing the total costs of Surgical Implant(s) and summing the total costs of any Associated Disposable Instrumentation that are utilized during the procedure. These costs are then multiplied by the corresponding percentages.

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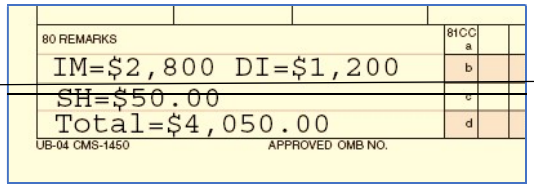
~~12~~	~~**Request for Surgical Implant Reimbursement**~~	~~In order to receive reimbursement for Surgical Implant(s) and associated costs, the ASC must either:~~ • ~~Certify in writing on the DWC-90 claim form, in Form Locator 80 ("Remarks"), that the total requested reimbursement per category of Surgical Implant(s), Associated Disposable Instrumentation, and Shipping & Handling has been determined in accordance with the reimbursement percentages defined by the policy in this Manual.~~ ~~Each such total amount requested for reimbursement must be listed separately on the DWC-90 claim form in the Form Locator 80 ("Remarks"), using each of the modifiers prescribed in this Manual and their associated total dollar amounts for requested reimbursement pursuant to this Manual.~~ ~~On the DWC-90 claim form, in Form Locator 80 ("Remarks"), the ASC must separately list the abbreviation of each category immediately preceding the amount of expected reimbursement for each category used which is calculated pursuant to this Manual. Each category must be identified by the Florida Workers' Compensation unique modifier, e.g. for Surgical Implants (IM), Associated Disposable Instrumentation (DI), and Shipping and Handling (SH). An example would be:~~  80 REMARKS 81CC IM=$2,800 DI=$1,200 a SH=$50.00 b Total=$4,050.00 c d UB-04 CMS-1450 APPROVED OMB NO. ~~or~~ • ~~Submit to the carrier a copy of the implant log, found in the operative records, and documentation of the Associated Disposable Instrumentation used for implantation. This documentation must list the items on the attached manufacturer's acquisition invoice(s) substantiating the utilization and manufacturer's acquisition invoice cost of the Surgical Implant(s) and Associated Disposable Instrumentation billed.~~

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12	**Surgical Implant Reimbursement**	Surgical Implant(s) must be billed ~~itemized~~ separately from the surgical procedure code(s) and are reimbursed in addition to the surgery. The ASC must ~~will~~ be reimbursed for the Surgical Implant(s) ~~at~~: • According to an agreed upon contract price; or • Thirty ~~fifty~~ percent (30 ~~50~~%) over the ~~manufacturer's~~ acquisition invoice cost. The ASC must ~~will~~ be reimbursed for the Associated Disposable Instrumentation required for implantation of the Surgical Implant(s) ~~at~~: • According to an agreed upon contract price; or • T~~t~~wenty percent (20%) over the ~~manufacturer's~~ acquisition invoice cost~~., if the Associated Disposable Instrumentation is received with the Surgical Implant(s) and included on the same manufacturer's acquisition invoice.~~ ~~Associated Disposable Instrumentation must be documented with unit price, quantity utilized, and total costs of each item used for implantation.~~ Associated Disposable Instrumentation is only reimbursed for those surgeries requiring Surgical Implants. The ASC must ~~will~~ be reimbursed for Shipping and Handling at the actual cost to the ASC if listed on the ~~manufacturer's~~ acquisition invoice. Reimbursement is not made for sales tax. ~~**Note:** Surgical Implants, Associated Disposable Instrumentation, and Shipping and Handling may be certified for the amount the ASC is requesting, pursuant to the policy for **Certification of Surgical Implant Reimbursement Amount** stated in this Manual.~~
12	**Undocumented Charges for Surgical Implant(s)**	Charges for Surgical Implant(s) billed under the Surgical Implant Revenue Code 0278 that meet any of the conditions below ~~will~~ constitute undocumented charges and must ~~will~~ be adjusted or disallowed. ~~• Not properly certified;~~ ~~• Not separately identified per category (IM, DI, or SH);~~ • Submitted without implant logs; • Submitted without documentation listing the Associated Disposable Instrumentation used for implantation; or • Submitted without acquisition invoices for the Surgical Implant(s) ~~invoices~~ and ~~invoices for~~ Associated Disposable Instrumentation~~, when not certified~~. ~~**Note:** See **Certification of Surgical Implant Reimbursement Amount**.~~ **Note:** Instructions contained in this Manual ~~Rule Chapter 69L-7, F.A.C.,~~ must be followed ~~used~~ to bill Surgical Implant(s), Associated Disposable Instrumentation, and Shipping and Handling~~. in Form Locator 42 on the DWC-90 claim form.~~ The Workers' Compensation Unique Procedure Codes for Surgical Implants, Associated Disposable Instrumentation, and Shipping and Handling, with ~~and~~ their required modifiers, must be billed on separate lines in Form Locator 44.

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13	**Verification of Surgical Implant(s) Cost and Charges**	~~The ASC's certification of the amount requested for reimbursement, whether in writing by a designee of the ASC, by prior written agreement with the carrier, or by the billing form, and the ASC's compliance with the billing requirements in this Manual and Rule Chapter 69L-7, F.A.C., will be subject to verification through audit and medical record review.~~ Upon request by the Division, ~~or~~ a carrier, or its designee, to conduct an audit or medical record review, the ASC must produce a copy of the ~~manufacturer's~~ acquisition invoice(s) 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. Nothing in this policy is intended to create, alter, diminish, or negate any protections regarding the confidentiality of any cost information produced during the course of such an audit.
~~13~~	~~**Certification of Surgical Implant and Reimbursement**~~	~~Certification of Surgical Implants and associated costs on a medical bill means the ASC is declaring that the amount requested for reimbursement in Form Locator 80 of the billing form for reimbursement of the Surgical Implant(s) is fifty percent (50%) over the manufacturer's acquisition invoice cost and the reimbursement of the Associated Disposable Instrumentation is twenty percent (20%) over the manufacturer's acquisition invoice cost.~~ ~~When certifying for reimbursement of the Associated Disposable Instrumentation, documentation must be maintained by the ASC supporting the Associated Disposable Instrumentation was received on the same manufacturer's acquisition invoice as the Surgical Implant.~~ ~~Shipping and Handling is reimbursed at the actual cost to the ASC.~~ ~~Certification for reimbursement of Surgical Implants and their associated costs, as specified in this Manual, must only 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 legible signed, written statement from the ASC or a designee of the ASC, which includes the name, title, and affiliation of the individual providing the accompanying 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 must place the amount for each separate category requested for reimbursement in the Form Locator 80 ("Remarks").~~

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13	**Multiple Surgery Reimbursement Amount**	~~Reimbursement will be made for all medically necessary surgical procedures~~ W~~w~~hen more than one (1) procedure is performed during a single operative session~~.~~ e~~E~~ach surgical procedure performed must be identified by using the appropriate five-digit CPT® code and listed separately. The most comprehensive surgical procedure code, which is the primary surgical procedure scheduled for the injured worker, must be listed first without ~~must not be~~ appending~~ed with~~ modifier 51. Each additional surgical procedure code must be listed separately and appended with modifier 51. Reimbursement must be made consistent with the requirements of **Reimbursement for Surgical Services** described earlier in this Manual.
13	**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. For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price; • The MRA listed in Appendix A; or • If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B. ~~Reimbursement will be made for bilateral procedures listed as bilateral in CPT® as follows:~~ ~~The ASC will be reimbursed:~~ ~~• The MRA if the procedure code is listed in this Manual;~~ ~~• Sixty percent (60%) of the billed charge if not listed in this Manual; or~~ ~~• The agreed upon contract price.~~ ~~If the CPT® code is identified as an unlisted procedure or service in the CPT® manual, the CPT® code will be priced by the carrier as By Report.~~ ~~CPT only copyright 2017 American Medical Association. All rights reserved.~~
13	**Reimbursement for Bilateral Procedures Not Listed as Bilateral in CPT**	Procedures performed bilaterally, that do not contain the word "bilateral" in the CPT® description, 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. For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price; • The MRA listed in Appendix A; or • If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B.

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13	**Reimbursement for Bilateral Procedures Not Listed as Bilateral in CPT (continued..)**	~~Reimbursement will be made for bilateral procedures not listed as bilateral in CPT® as follows:~~ ~~For surgical procedures listed in this Manual, the ASC will be reimbursed as:~~ • ~~The MRA; or~~ • ~~The agreed upon contract price.~~ ~~For surgical procedures not listed in this Manual, the ASC will be reimbursed as either:~~ • ~~Sixty percent (60%) of billed charges; or~~ • ~~The agreed upon contract price.~~ ~~If the CPT® code is identified as an unlisted procedure or service in the CPT® manual, the CPT® code will be priced by the carrier as By Report.~~
13	**Bilateral Procedures Performed Unilaterally**	When a procedure is performed unilaterally, and the procedure description in CPT® states "bilateral," the service must be identified with a modifier 52. For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price. • Fifty percent (50%) of the MRA listed in Appendix A; or • If the billed CPT® code is not listed in Appendix A, Fifty percent (50%) of the MRA listed in Appendix B. ~~**Note**: Reimbursement will be fifty percent (50%) of the **Reimbursement for Surgical Services** described earlier in the Manual.~~
14	**Post-Operative Pain Management**	Nerve blocks for post-operative pain management must ~~will~~ be reimbursed if ordered by the surgeon and provided in addition to general anesthesia or conscious sedation. Nerve blocks for post-operative pain management may be performed pre-operatively, intra-operatively, or post-operatively. A copy of the surgeon's order for post-operative pain management, along with a copy of the anesthesia provider's separate procedural report for the performance of the nerve block, must be submitted to the carrier for reimbursement. ~~Reimbursement for post-operative nerve blocks will be made consistent with the requirements of **Reimbursement for Surgical Services** in this Manual.~~ For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price; • The MRA listed in Appendix A; or • If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B. The professional component for nerve blocks must be billed by the health care practitioner on the DFS-F5-DWC-9 (CMS-1500) claim form.

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14	**Terminated Procedures**	A bill submitted for reimbursement of a terminated surgery must include documentation that specifies the following: • Reason for termination of surgery; and • ~~Services reported by each CPT® code, that were actually performed; or~~ • A comprehensive ~~single~~ CPT® code describing the primary procedure had the scheduled surgery been performed. Modifier 73 or 74 must be added to the procedure code~~s~~ scheduled to be performed or actually performed to identify the circumstances under which the services were terminated consistent with CPT® coding rules. ~~CPT only copyright 2017 American Medical Association. All rights reserved.~~
14	**Reimbursement for Terminated Procedures**	Reimbursement must ~~will~~ not be made for a procedure terminated either for medical reasons or non-medical reasons before the pre-operative procedures are initiated by staff. Reimbursement for Terminated Procedures must ~~will~~ be made consistent with the following ~~requirements~~: • ~~Reimbursement will be fifty percent (50%) of **Reimbursement for Surgical Services** I~~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~~.~~, reimbursement is as follows: For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price; • Fifty percent (50%) of the MRA listed in Appendix A; or • If the billed CPT® code is not listed in Appendix A, Fifty percent (50%) of the MRA listed in Appendix B. Bill using modifier 73. • ~~Reimbursement will be one hundred percent (100%) of the **Reimbursement for Surgical Services** I~~if a procedure is terminated due to a medical complication that arises causing the procedure to be terminated after induction of anesthesia~~.~~, reimbursement is as follows: For each billed CPT® code the ASC must be reimbursed either: • According to an agreed upon contract price; • The MRA listed in Appendix A of the comprehensive procedure; or • If the billed CPT® code is not listed in Appendix A, the MRA listed in Appendix B of the comprehensive procedure. Bill using modifier 74.

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15	**Out of State Facility**	ASC services provided ~~by an out-of-state facility require prior authorization by the carrier. An ASC~~ outside of the state of Florida must ~~will~~ be reimbursed: • According to an ~~for the amount mutually~~ agreed upon ~~in a~~ contract price, pursuant to obtaining authorization as required by this Manual ~~between the ASC and the carrier during the authorization process~~. • If no agreed upon contract price has been pre-approved, the ASC must be reimbursed the greater of: 1. The amount of reimbursement established under the Workers' Compensation statute where the ASC is located; or 2. The MRA as determined using this Manual, including the limitations on reimbursement for radiology and clinical laboratory services. ~~If reimbursement is not agreed upon prior to rendering the service, reimbursement will be the greater of:~~ ~~• The **Reimbursement for Surgical Services** described earlier in this Manual; or~~ ~~• The reimbursement amount of the state in which the service(s) are rendered.~~
~~15~~	~~**Disallowance and Adjustment of Itemized Charges**~~ **(Moved to the section "Disallowed, Denied, and Disputed Charges".)**	~~The carrier will 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;~~ ~~• Not documented in the patient's medical record;~~ ~~• Not consistent with the ASC's Charge Master;~~ ~~• 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.~~
16	**Minimum Partial Payment Required**	Whenever a carrier denies, disallows, or adjusts payment for ASC charges, in accordance with the time limitation and coding requirements established by statute and by rule ~~Rule Chapter 69L-7, F.A.C., and section 440.20(2)(b), F.S.~~, the carrier must ~~will~~ remit a minimum partial payment of the ASC's charges, which payment must accompany the Explanation of Bill Review (EOBR). ~~and the minimum partial payment will accompany an Explanation of Bill Review (EOBR).~~ The carrier must remit minimum partial payment according to the applicable reimbursement for each CPT® or Workers' Compensation Unique Procedure Codes billed for each of the itemized charges that are not denied, disallowed, or adjusted for which the ASC obtained authorization in accordance with this Manual, and for which there is no dispute as to the medical necessity.
~~16~~	~~**Reimbursement Disputes**~~	~~The ASC may elect to contest the disallowance or adjustment of payment under section 440.13(7), F.S., and Rule Chapter 69L-31, F.A.C.~~ ~~The election to contest the disallowance or adjustment of payment under section 440.13(7), F.S., must be made by the ASC within forty-five (45) calendar days of receipt of the EOBR or notice of disallowance or adjustment of payment.~~

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16	**Disallowance and Adjustment of Itemized Charges**	The carrier must disallow or adjust reimbursement for any charges that are: • Billed with Category III CPT® procedure codes that are not authorized by the Workers' Compensation carrier prior to the procedure; • Not documented in the patient's medical record; • 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 • except when treatment, for the episode of care, is required to stabilize or maintain the patient's medical status in order to treat the patient's compensable injury or condition.
17	**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.~~
17	**Bill Completion**	An ASC bill must ~~will~~ be properly completed according to the form completion instructions incorporated in paragraph 69L-7.720(1)(e), F.A.C. The DWC-90, incorporated in paragraph 69L-7.720(1)(e), F.A.C., will 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 the DWC-90 claim form 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.~~
17	**Billing on the DWC-90**	ASCs must bill using the DWC-90 claim form. ASCs must only bill for the services performed and documented in the medical records. Form DFS-F5-DWC-90-B (UB-04), Completion Instructions, are ~~is~~ the set of instructions for completing the form for dates of service on and ~~or~~ after 7/8/2010.
18	**Codes and Modifiers for Billing**	An ASC must report Revenue Codes in Form Locator 42 of the DWC-90 claim form, in addition to CPT® codes or Workers' Compensation Unique Procedure Codes in Form Locator 44, when required. When reporting multiple procedures performed during a single operative session, an ASC must report the appropriate Revenue Code in Form Locator 42 on each line with the corresponding CPT® code in Form Locator 44. Modifiers must be used when appropriate. **Note:** ASCs must utilize the Workers' Compensation Unique Modifier CZ with any billed CPT® code that is not listed in **Appendix A** in this Manual. **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-7.100, F.A.C.

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18	**Surgical Implant(s) Billing**	Surgical Implants and Associated Disposable Instrumentation must be billed using only Revenue Code 0278 in Form Locator 42 of the DWC-90. 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 ~~When not certified~~, T~~t~~he ~~manufacturer's~~ acquisition invoices reflecting the ASC's actual cost for the Surgical Implants, Associated Disposable Instrumentation used for the implantation only, and Shipping and Handling must accompany the bill for the reimbursement of each component of Surgical Implants and Associated Disposable Instrumentation. All ~~manufacturer's~~ acquisition invoices must be clearly marked identifying which ~~what~~ items of Surgical Implants~~,~~ and Associated Disposable Instrumentation~~, and Shipping and Handling,~~ are used during the surgery. The Surgical Implant Log and documentation of the Associated Disposable Instrumentation utilized for implantation are required for reimbursement. ~~When certified pursuant to the policy in this Manual, the requested reimbursement amount for Surgical Implants may be entered 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 this Manual must be entered in Form Locator 80. The requested amount for each category must 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 in this Manual. 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. ~~CPT only copyrighted 2017 American Medical Association. All rights reserved.~~
20	**Form DFS-F5-DWC-90 Completion Instructions**	**In order to access forms on DWC's website, please click on the "Forms" tab located on the ~~left side of~~ main website, and then click on "Rule Chapter 69L-7."** Form DFS-F5-DWC-90-B (UB-04), Completion Instructions, may be obtained from DWC's website for dates of service on and ~~or~~ after 07/08/2010. ~~Form DFS-F5-DWC-9-C, Completion Instructions, may be obtained from DWC's website for date(s) of service prior to 07/08/2010.~~

<table>
<tr><th>Page #</th><th>Section/Paragraph Titles</th><th>Text Change</th></tr>
<tr><td>21</td><td><s>Appendix A:</s> Workers' Compensation Unique Procedure Codes</td><td>
<table>
<tr><th>FL Workers' Compensation Unique Procedure Code</th><th>FL Workers' Compensation Unique Procedure Code Description</th><th>MRA</th></tr>
<tr><td>99070 IM</td><td>Surgical Implant(s)</td><td>According to an agreed upon contract price or thirty percent (30%) over <s>Amount certified, or contract amount, or fifty percent (50%) above manufacturer's</s> acquisition invoice cost.</td></tr>
<tr><td>99070 DI</td><td>Associated Disposable Instrumentation used for Surgical Implant(s).</td><td>According to an agreed upon contract price or <s>Amount certified, or contract amount, or</s> twenty percent (20%) over <s>above manufacturer's</s> acquisition invoice cost.</td></tr>
<tr><td>99070 SH</td><td>Shipping and Handling costs for Surgical Implant(s) and Associated Disposable Instrumentation, listed on the acquisition invoice.</td><td>According to an agreed upon contract price or <s>Amount certified, or contract amount, or</s> actual cost on <s>manufacturer's</s> acquisition invoice.</td></tr>
</table>
Note: Workers' Compensation Unique Procedure Code and Modifier combinations 99070 IM, 99070 DI, and 99070 SH are reimbursed pursuant to the policy for Surgical Implant Reimbursement in this Manual.
</td></tr>
<tr><td>40</td><td>Definitions:</td><td>2. Associated Disposable Instrumentation (ADI) 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 neuro-stimulators. 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, suture material and any form of drainage catheter or system. <s>For the purpose of determining reimbursement according to this Manual, any requests for reimbursement of Associated Disposable Instrumentation must be reflected on the same manufacturer's acquisition invoice as the Surgical Implant(s).</s>
<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.</s>
<s>4. By Report means a reimbursement allowance made by the carrier based on specific documentation containing the complete description of the services, procedures, prevailing charges, and reimbursement for clinically similar procedures or cost of the services.</s>
<s>5. Certification means Surgical Implants, and Associated Disposable Instrumentation, and any Shipping and Handling costs the ASC is declaring the amount requested for reimbursement in Form Locator 80 on the billing form. The requested reimbursement for the Surgical Implant(s) billed under Revenue Code 0278 does not exceed fifty percent (50%) over the manufacturer's acquisition invoice cost, and the Associated Disposable Instrumentation does not exceed twenty percent(20%) over the manufacturer's acquisition invoice cost as listed on the same acquisition invoice as the Surgical Implant, and the shipping and handling does not exceed actual invoice cost.</s></td></tr>
</table>

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40	**Definitions: (continued...)**	**3. 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, by item description, unit size, unit price, and all identifying information maintained by the ASC, regardless of payer type. The Charge Master must be maintained, and relevant portions must be produced, either by paper or electronically, for those charges billed by the ASC for an injured employee, when requested for the purpose of verifying ~~its usual~~ charges. ~~pursuant to section 440.13(12)(d), F.S.~~ **11. Surgical Implant** means, ~~for the purpose of determining reimbursement according to this Manual,~~ any single-use item that is surgically inserted and meets the definition of ~~deemed to be~~ medically necessary, pursuant to section 440.13(1)(k), F.S., ~~by an authorized physician,~~ which the physician does not specify to be removed in less than six weeks.~~,~~ Examples of such items are ~~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 neuro-stimulators; and permanent pain pumps.