Florida Workers' Compensation
Reimbursement Manual for Hospitals, 2020 Edition

Notice of Proposed Rule Changes
Draft Rule 69L-7.501, F.A.C.
Hearing Date: 08/30/2022

SUMMARY OF CHANGES PROPOSED RULE 69L-7.501, F.A.C.

RULE REVISION OVERVIEW:

Proposed Draft Rule 69L-7.501, Florida Administrative Code (F.A.C.), incorporates the following updates to the Florida Workers' Compensation Reimbursement Manual for Hospitals, 2020 Edition; changes have been made in punctuation, grammar, 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 Ambulatory Surgical Centers; the American Medical Association CPT copyright statement was placed in the page footer; references to the word "will" and "shall" are stricken and replaced with the word "must"; inpatient and outpatient reimbursement methodologies have been updated; surgical implant reimbursement has been updated; redundant reimbursement policy has been stricken; updates have been made to the Appendix A geographic modifiers and the Appendix B and Appendix C base rates. A new table of base rates has been developed for procedures not found in Appendices B and C.

RULE HISTORY:

Rule 69L-7.501, F.A.C., the Florida Division of Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition (Effective October 1, 2007)

Rule 69L-7.501, F.A.C., the Florida Division of Workers' Compensation Reimbursement Manual for Hospitals, 2014 Edition (Effective January 1, 2015)

PROPOSED CHANGES:

Page #	Section/Paragraph Titles	Text Change
4	----------	The ~~referenced~~ five-character codes included in the Florida Workers' Compensation Reimbursement Manual for Hospitals, 2020~~18~~ Edition, are obtained from the Current Procedural Terminology (CPT), copyright 2019~~17~~ 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 Hospitals, 2020~~18~~ Edition, is with ~~DFS~~ the Department of Financial Services 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 Hospitals, 2020~~18~~ 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 Hospitals, 2020~~18~~ Edition, should refer to the most ~~current~~ Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. CPT is a registered trademark of the American Medical Association.

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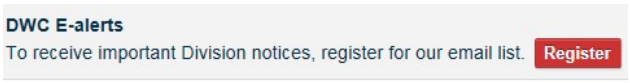
5	Changes to the Manual	It is important that hospitals and carriers read the updated material in this Florida Workers' Compensation Reimbursement Manual for Hospitals (Manual). Both parties have a responsibility for performing certain duties when billing, reporting, or reimbursing ~~filing or paying~~ Workers' Compensation medical bills for treatment of injured workers. ~~Reimbursement Manuals will be available under the "Reimbursement Manuals" section on the DWC website at https://www.myfloridacfo.com/Division/WC/~~.
5	E-Alert System	The Division of Workers' Compensation (DWC) ~~Division~~ has an electronic alert (E-Aalert) 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, https://www.myfloridacfo.com/Division/WC/. Look for the ~~box entitled~~ "Register" link near ~~on~~ the bottom of the page ~~right~~. Once completed ~~registered~~, you will receive E-Alerts whenever they are provided by the Division. 
~~5~~	~~Background~~	~~There are 3 types of Workers' Compensation Manuals:~~ • ~~Florida Workers' Compensation Reimbursement Manual for Hospitals, Rule 69L-7.501, Florida Administrative Code (F.A.C.);~~ • ~~Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, F.A.C.;~~ • ~~Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C.~~
~~5~~	~~Other Applicable Rules~~	~~In addition to this Manual, Rule 69L-7.501, F.A.C., also recognizes the following regulations:~~ • ~~Rule Chapter 69L-7, F.A.C.; and~~ • ~~Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C.~~
5	Legal Authority	The following statutes and rule chapter govern Wworkers' Ccompensation 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 Statutes and Florida Administrative Code for each service are cited for reference ~~in each specific manual~~, where appropriate.

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6	Purpose	~~Section 440.13(12)(a), F.S., provides that "[a]nnually, the Three-Member Panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs."~~ The Manual contains the Maximum Reimbursement Allowances (MRAs) ~~determined~~ using the methodology approved by the Three-Member Panel for reimbursing services performed in the hospital setting. ~~and establishes policies, procedures, principles, and standards for implementing statutory provisions regarding reimbursement for medically necessary services and supplies provided to injured workers in a hospital setting.~~ 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, Third Party Administrator (TPA), or any other entity acting on behalf of a carrier for the purposes of administering Workers' Compensation 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. ~~The carrier will be held accountable for all actions taken by a service company, third party administrator (TPA), or other entity acting on its behalf when adjusting, reimbursing, disallowing, or denying reimbursement to hospitals.~~
6	Fraud Statement	Any hospital 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 ~~will~~ 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."
6	Carrier Responsibilities	A carrier is responsible for meeting its obligations under this Manual and is accountable 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, disallowed or denied to hospitals. Carriers must inform ~~in-state and out-of-state~~ hospitals 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 hospital 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). 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 to the Department, upon request.

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~~6~~	~~Billing and Reporting~~	~~Hospitals and 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).~~ ~~Additional billing, reporting, and documentation requirements specific to requesting reimbursement for Surgical Implants when used in an inpatient hospital setting are set forth in this Manual.~~
6	Hospital Responsibilities	A hospital 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. Hospitals must provide the carrier additional form completion requirements or supporting documentation beyond those required in Rule Chapter 69L-7, F.A.C., which the carrier may require for a reimbursement decision ~~determination when the carrier informs the hospital, in writing, at the time hospital services are authorized.~~
6	Prior Authorization of Services	Both Florida facilities and out-of-state hospital facilities must be authorized by the W~~w~~orkers' C~~c~~ompensation 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. 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. 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, hospital participation in the Workers' Compensation system, the cost of the claim, and the number of medical reimbursement disputes. Therefore, it is imperative the hospital 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.
~~7~~	~~Authorization of Non-Emergency Services and Care~~	~~A hospital must obtain authorization from the carrier prior to providing any non-emergency medical treatment, care, or attendance for a patient's work-related injury or condition.~~

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7	Emergency Services and Care	Emergency services and care, defined in section 395.002, F.S., do not require authorization at the time they are rendered. A hospital that renders emergency care must notify the carrier by the close of the third state of Florida business day after it has rendered such care. ~~However,~~ W~~w~~hen an emergency medical condition requires or results in a hospital ~~health care facility~~ inpatient admission, the hospital must notify the carrier ~~by telephone~~ within 24 hours of the initial treatment. When it is determined that an emergency medical condition, as defined in section 395.002, F.S., does not exist or no longer exists~~,~~ and only non-emergency ~~follow-up examination or~~ services are required ~~or recommended~~, the carrier must ~~expressly~~ authorize any ~~further~~ non-emergency ~~related~~ follow-up care, treatment, or referrals, pursuant to section 440.13(3), Florida Statutes ~~prior to the provision of the additional treatment or care~~.
~~8~~	~~Medical Records~~	~~Hospitals must create and maintain medical records of all workers' compensation claimants in accordance with the form and content required by section 395.3015, F.S., and Rule 59A-3.270, F.A.C., and may not release any identifying medical record(s) or protected health information, except as allowed or required by law.~~
8	Billing ~~Disclosure~~ to Carriers	When requested by the carrier, ~~At a minimum,~~ it is the responsibility of the hospital to furnish, without charge, the following documentation to the carrier: ~~with the hospital bill~~: • An operative or procedural report when a surgical procedure is performed; • ~~Manufacturer's~~ Aacquisition invoices and the Implant Log, found in the operative records, for Surgical Implant(s), Associated Disposable Instrumentation, and Shipping & Handling~~, when Surgical Implants and their associated costs are not certified pursuant to the policy~~; and • ~~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 hospital is by manufacturer's acquisition invoice cost or by hospital certification; and~~ • ~~Any~~ Ccopies of any additional medical records. ~~required by the employer or carrier, provided the hospital received written notification from the employer or carrier of this being a required component for reimbursement when the services were authorized.~~ Failure of the hospital to submit documentation ~~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 decision.~~
~~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, hospitals 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.~~

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8	Copying Charges for Medical Records	Copying charges for medical records are made pursuant to ~~An injured worker or injured worker's attorney requesting copies of medical records must reimburse the hospital for copying charges according to section~~ paragraph 440.13(4)(b), F.S.~~, and Rule Chapter 69L-7, F.A.C., and the hospital may charge no more than 50 cents per page for copying the records and the hospital's actual direct costs for X rays, microfilm, or other non-paper records.~~ ~~No other copy charges or search charges may be charged to the injured worker or the injured worker's attorney as part of the services provided to the injured worker by the hospital.~~ ~~A carrier, employer, or authorized representative requesting copies of medical records must reimburse the hospital for copying charges according to section 395.3025, F.S.~~
8	Limits on Copying Charges	The limits on charges apply regardless of whether the retrieval and copying are performed in-house or contracted out for completion by a copy service or other medical record maintenance service~~, and also apply when the carrier requires hospital medical records submission with a bill in order for payment to be made or for the purpose of an audit or review conducted under this Manual~~. ~~The above charges apply to all copies of original documents requested by a carrier whether the request for the copies is made before services are rendered or after services are rendered.~~ ~~The above charges apply to all copies of original documents requested by a carrier regardless of whether the copies of documents are sent to the carrier for the purpose of performing an in-house desk audit or review in lieu of an on-site audit or review at the hospital, whether the request is made in the course of an on-site audit or medical record review, or whether the request for copies is for an entire document or for selected portion(s) of a document.~~ ~~Hospitals must not charge any fee when required by law or rule to produce any original medical, financial, or charge records for on-site audit or inspection by a carrier.~~ ~~Hospitals will not be reimbursed any charges for copies of medical records required by the Division or by the Office of Judges of Compensation Claims in performance of their statutory duties implementing and enforcing the Workers' Compensation law.~~

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8	Division or Judge of Compensation Claims Requests	A hospital, upon request, must provide medical records and reports to the Division or a Judge of Compensation Claims without charge.
9	Reported Charges	Charges for hospital inpatient services must be reimbursed: • According to an agreed upon contract price; or • According to the Per Diem Schedule provided in this Manual. The length of hospital stay must be pre-certified by the carrier. ~~Except as otherwise provided in this Manual, charges for hospital inpatient services will be reimbursed according to the Per Diem Schedule provided in this Manual or according to an agreed upon contractual reimbursement agreement between the hospital and the carrier. The length of hospital stay must be pre-certified according to the provisions in this Manual.~~ **Note:** See **Pre-Certification of Length of Stay** ~~in this Manual.~~
9	Determining Surgical Stay ~~or Non-Surgical Stay~~	The determination of whether inpatient services ~~rendered~~ are surgical must ~~or non-surgical will~~ be based on the presence of ~~any of~~ the following revenue code(s) 0360, 0361, 0362, 0367, or 0369, in conjunction with revenue code(s) 0370 or 0379, ~~for the same date of service on the hospital bill~~ in Form Locator 42 on Form DFS-F5-DWC-90/UB-04 CMS-1450 (DWC-90). The surgical procedure ~~or non-surgical status~~ must be substantiated by the Operative Report and the Anesthesia Report for the services provided to the injured worker.
9	Per Diem Schedule	~~Except as otherwise provided in the Manual, the hospital will be reimbursed according to the surgical or non-surgical per diem schedule for each admission as indicated.~~ ~~If the Total Gross Charge After Implant Carve-Out is $69,468.00 or less, reimbursement will be determined according to the following per diem allowances:~~ ~~Inpatient services provided by a Trauma Center licensed pursuant to section 395.4025, F.S.:~~ ~~1. Surgical stay: $4,466.00 per day.~~ ~~2. Non-surgical stay: $2,684.00 per day.~~ **Note:** ~~For a list of Trauma Center contact information, please see the Department of Health (DOH) at www.doh.state.fl.us.~~ ~~Inpatient services provided by other acute care hospitals:~~ ~~1. Surgical stay: $4,465.00 per day.~~ ~~2. Non-surgical stay: $2,649.00 per day.~~ If the charges for any day of hospitalization are less than the applicable per diem allowance established in this Manual, the hospital will be reimbursed the per diem allowance for the day(s) rather than the lesser amount charged by the hospital.

<table>
<tr><th>Page #</th><th>Section/Paragraph Titles</th><th>Text Change</th></tr>
<tr><td>9</td><td>Per Diem Schedule (continued…)</td><td>The carrier must ~~will~~ not disallow a per diem rate ~~allowance~~ for any day of an inpatient stay unless the documentation in the medical record does not support the medical necessity for each of the estimated number of days that were pre-certified, or the actual length of stay exceeds the estimated days that were pre-certified by the carrier and the medical record does not substantiate the medical necessity for the additional inpatient day(s).

The carrier must ~~will~~ not reimburse a per diem rate ~~allowance~~ for the day of discharge.</td></tr>
<tr><td>9</td><td>Per Diem Rates</td><td>
<table>
<tr><th>TIER</th><th>RATE</th></tr>
<tr><td>Tier 1 – All other revenue codes (non-surgical stay)</td><td>$7,000</td></tr>
<tr><td>Tier 2 – Operating Room and Anesthesia (surgical stay)</td><td>$11,000</td></tr>
<tr><td>Tier 3 – Intensive and Coronary Care (Revenue Codes 0200-0209 and 0210-0219)</td><td>$13,000</td></tr>
</table>

Note: An inpatient hospital stay is reimbursed at either a Tier 1 (non-surgical stay) or Tier 2 (surgical stay) per diem rate for the length of stay, except for those days billed for Intensive and Coronary Care. The Tier 3 rate is applied for the specific Intensive and Coronary Care days.

Reimbursement examples for an inpatient hospital stay:

Example 1 (Surgical stay with intensive care):
The inpatient hospital bill is submitted for reimbursement. Revenue codes 0110, 0360, 0370, and 0200 are billed in separate line items, in Form Locator 42, on the DWC-90 hospital billing form.

The patient was discharged on day eight of the inpatient stay.

Reimbursement is determined as follows:
<table>
<tr><th>TIER</th><th>CALCULATION</th></tr>
<tr><td>Tier 2 – Operating Room and Anesthesia (surgical stay)</td><td>$11,000 (per diem rate) x 5 days (room & board) = $55,000</td></tr>
<tr><td>Tier 3 – Intensive and Coronary Care (Revenue Codes 0200-0209 and 0210-0219)</td><td>$13,000 (per diem rate) x 2 days (intensive care unit) = $26,000</td></tr>
</table>

Reimbursement for the seven-day inpatient hospital stay = $81,000.00.
</td></tr>
</table>

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<tr><th>Page #</th><th>Section/Paragraph Titles</th><th>Text Change</th></tr>
<tr><td>9</td><td>Per Diem Rates
(continued…)</td><td>Example 2 (Surgical stay with no intensive care):
The inpatient hospital bill is submitted for reimbursement. Revenue codes 0110, 0360 and 0370 are billed on separate line items, in Form Locator 42, on the DWC-90 hospital billing form.

The patient was discharged on day eight of the inpatient stay.
Reimbursement is determined as follows:

<table><tr><th>TIER</th><th>CALCULATION</th></tr><tr><td>Tier 2 – Operating Room and Anesthesia (surgical stay)</td><td>$11,000 (per diem rate) x 7 days (room & board) = $77,000</td></tr></table>
Reimbursement for the seven-day inpatient hospital stay = $77,000.00.</td></tr>
<tr><td>10</td><td>Discharge within 24 Hours of Admission</td><td>When a discharge occurs within 24 hours of admission to a hospital facility, reimbursement must be according to an agreed upon contract price or the applicable per diem rate. ~~not exceed the applicable per diem allowance for a single day, unless the hospital indicates that the injured worker expired within the 24 hours.~~
~~If the injured worker expires within 24 hours of admission, the hospital will be reimbursed either the per diem amount or 75% of billed charges, whichever is greater.~~</td></tr>
<tr><td>~~10~~</td><td>~~Exceptions to Per Diem~~</td><td>~~Before calculating the amount of reimbursement for inpatient services according to this Manual, charges for Surgical Implant(s) must be separated out from the Total Gross Charges for which reimbursement is requested.~~

~~If the Total Gross Charge After Implant Carve-Out exceeds $69,468.00 reimbursement will be determined according to the **Stop-Loss Reimbursement** method.~~</td></tr>
<tr><td>~~10~~</td><td>~~Stop-Loss Reimbursement~~</td><td>~~If the Total Gross Charge After Implant Carve-Out exceeds $69,468.00, the hospital will be reimbursed seventy-five percent (75%) of the Total Gross Charge After Implant Carve-Out, except as otherwise provided in this Manual. The carrier will not reimburse a per diem allowance for the day of discharge.~~</td></tr>
<tr><td>10</td><td>Billing for Surgical Implants and Associated Disposable Instrumentation</td><td>Surgical Implants and Associated Disposable Instrumentation must be billed using Revenue Code 0278 on two separate lines of the hospital billing form.

To be eligible for reimbursement of Surgical Implant(s) and their associated costs, the hospital 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;
• 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</td></tr>
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10	Billing for Surgical Implants and Associated Disposable Instrumentation (continued…)	• 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 in this Manual. ~~All hospitals must report Surgical Implant charges and Associated Disposable Instrumentation required for the Surgical Implant according to the National Uniform Billing Committee, Official UB-04 Data Specifications Manual (UB-04 Manual), incorporated by reference into Rule 69L-7.501, F.A.C.~~ ~~Hospitals must identify charges for Surgical Implant(s) and Associated Disposable Instrumentation on the hospital billing form in the required Form Locator by using the designated Revenue Code 0278, "Other Implant", provided in the UB-04 Manual.~~ ~~Reimbursement for Surgical Implants and Associated Disposable Instrumentation must be billed only under Revenue Code 0278.~~
10	Surgical Implant Reimbursement	Surgical Implant(s) must be billed separately on the hospital bill and are reimbursed in addition to the per diem rate. Reimbursement for Surgical Implant(s) required during inpatient hospitalization must be: • According to an agreed upon contract price; or • Thirty percent (30%) over the acquisition invoice cost. Associated Disposable Instrumentation must be billed separately on the hospital bill and are reimbursed in addition to the per diem rate. Reimbursement for the Associated Disposable Instrumentation required for the implantation of the Surgical Implant(s) must be: • According to an agreed upon contract price; or • Twenty percent (20%) over the acquisition invoice cost. Associated Disposable Instrumentation is only reimbursed for those surgeries requiring Surgical Implants. The hospital must be reimbursed for Shipping and Handling at the actual cost to the hospital only when the cost is listed on the acquisition invoice. No reimbursement is made for sales tax. ~~Reimbursement for Surgical Implant(s) required during inpatient hospitalization will be sixty percent (60%) over the manufacturer's acquisition invoice cost for the implant(s).~~ ~~Reimbursement for the Associated Disposable Instrumentation required for the implantation of the Surgical Implant will be twenty percent (20%) over the manufacturer's acquisition invoice cost, if the Associated Disposable Instrumentation is received with the Surgical Implant and included on the manufacturer's invoice.~~ ~~Reimbursement for shipping and handling will be at actual cost shown on the invoice.~~

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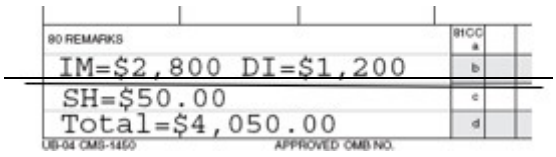
~~10~~	~~Surgical Implants in Addition to Per Diem or Stop-Loss~~	~~Reimbursement for Surgical Implant(s) and Associated Disposable Instrumentation will be in addition to reimbursement of the Total Gross Charge After Implant Carve-Out, regardless of whether the charge is reimbursed by the Per Diem method or the Stop-Loss Reimbursement method.~~ ~~**Note:** Contractual arrangements between a hospital and a carrier must specify the reimbursement amounts for "Surgical Implants."~~
10	Determining Surgical Implant Acquisition Cost	When determining the ~~manufacturer's~~ acquisition invoice cost of the Surgical Implant(s), the hospital must subtract any and all price reductions, offsets, discounts, adjustments, and/or refunds which accrue to, or are factored into, the final net cost to the hospital, only if they appear on the acquisition invoice, before increasing the invoice amount by the percentage factors described under **Surgical Implant Reimbursement** ~~above~~.
~~10~~	~~Request for Surgical Implant Reimbursement~~	~~In order to receive reimbursement for Surgical Implant(s) and associated costs, the hospital 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 and Handling has been determined in accordance with the reimbursement percentages defined by the policies in this Manual. Each such total amount requested for reimbursement must be listed separately on the DWC-90 claim form in Form Locator 80 ["Remarks"], using 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 hospital must separately list the abbreviation of each category e.g., immediately preceding the amount of expected reimbursement for each category used which is calculated pursuant to this Manual. Each reimbursement category must be identified by the Florida Workers' Compensation unique modifier, e.g. Surgical Implants (IM), Associated Disposable Instrumentation (DI), and Shipping and Handling (SH). The hospital must submit to the carrier copies of the implant log, found in the operative record, and documentation of the Associated Disposable Instrumentation used for implantation. The documentation must list the items, by manufacturer's acquisition invoice item name, substantiating the utilization of the Surgical Implant(s) and Associated Disposable Instrumentation billed.~~ ~~An example would be:~~  ~~or~~

Page #	Section/Paragraph Titles	Text Change
~~10~~	~~Request for Surgical Implant Reimbursement~~ (continued…)	• ~~The hospital must submit to the carrier copies 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 cost of the Surgical Implant(s) and Associated Disposable Instrumentation billed.~~
11	Undocumented Charges for Surgical Implant(s)	Charges 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; • Submitted without acquisition ~~Surgical Implant~~ invoices for the Surgical Implant(s) or ~~and invoices for~~ Associated Disposable Instrumentation~~, when not certified~~ **Note:** Instructions contained in this Manual must be followed to bill Surgical Implant(s), Associated Disposable Instrumentation, and Shipping and Handling. **~~Note~~:** See ~~**Certification of Implant Reimbursement Amount**~~.
~~11~~	~~Certification of Surgical Implant Reimbursement Amount~~	~~Certification of Surgical Implant and associated costs on a medical bill means the hospital is declaring that the amount requested for reimbursement in Form Locator 80 of the billing form for reimbursement of the Surgical Implant(s) billed under Revenue Code 0278 does not exceed sixty percent (60%) over the manufacturer's acquisition invoice costs and the Associated Disposable Instrumentation does not exceed twenty percent (20%) over the manufacturer's acquisition invoice cost.~~ ~~Certification of a medical bill that the amount requested for reimbursement for the Surgical Implant(s), Associated Disposable Instrumentation, and Shipping and Handling, as specified in this Manual, may be submitted as follows:~~ • ~~By a legible, signed, written statement which includes the name, title, department, and affiliation of the individual providing the accompanying request for the Surgical Implant reimbursement amount when submitting paper claims; or~~ • ~~According to a prior written agreement between the billing hospital and the carrier regarding reimbursement for Surgical Implant(s); or~~ • ~~Via the hospital billing form when submitting claims electronically or by paper.~~ ~~When certifying for reimbursement of the Associated Disposable Instrumentation, documentation must be maintained by the hospital 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 hospital.~~

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11	Verification of Surgical Implant Costs and Charges	~~The hospital's certification of amounts requested for reimbursement, whether by signed statement, by prior agreement, or via Form Locator 80 (labeled "Remarks") in the hospital billing form, and the hospital's compliance with billing and revenue code specifications in accordance with the UB-04 Manual and this Manual, incorporated by reference into Rule 69L-7.501, F.A.C., will be subject to verification through audit and medical record review pursuant to this Manual.~~ Upon request by ~~either~~ the Division, or a carrier or carrier's designee to conduct an audit or medical record review, as defined in this Manual, the hospital must produce a copy to the requester or make the original documents available for on-site review, or elsewhere by mutual agreement, such medical record(s) and Surgical Implant acquisition invoice purchasing documentation as requested within thirty (30) days of the request. ~~Neither a request nor completion of an audit will toll the time frame for petitioning the Division for resolution of a reimbursement dispute pursuant to section 440.13(7), F.S.~~ 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.
12	Introduction	~~Except as otherwise specified in this Manual, all compensable charges for hospital outpatient care must be reimbursed at 75% of usual and customary charges for medically necessary services and supplies (pursuant to section 440.13(12)(a), F.S.) and all scheduled outpatient surgery must be reimbursed at 60% of usual and customary charges.~~ Usual and customary charges are reimbursed based on median charges on ~~of~~ outpatient hospital bills, by CPT® code and HCPCS Level II® code, in a specific geographic area. Please see Appendix A of this Manual for the adopted geographic modifiers by county and Appendices B and C for a listing of ~~the~~ Base Rates by CPT® code and HCPCS Level II® code for ~~non-scheduled~~ outpatient services and scheduled surgical services. In the absence of a CPT® code or HCPCS Level II® ~~procedure~~ code in Appendices B and C, ~~the applicable Appendix or~~ reimbursement must be made according to an agreed upon contract price or pursuant to Appendix B.1 or Appendix C.1 (Base Rates for CPT® or HCPCS Level II® Codes Not Listed in Appendices B or C). ~~an agreed upon contract between the hospital and the carrier /employer, reimbursement must be made at the applicable percentage of the hospital's usual and customary charge.~~ In the event that a CPT® code or HCPCS Level II® code is substantially revised due to the creation of a new CPT® code or HCPCS Level II® code or a new CPT® code or HCPCS Level II® code is created in a CPT® manual released subsequent to the applicable CPT® manual incorporated by reference by rule, the hospital may bill, and the carrier may ~~must~~ reimburse, subject to any other provision of this Manual, statute, or applicable rule, such substantially revised or newly created CPT® code or HCPCS Level II® code. ~~at the applicable percentage of the hospital's usual and customary charge, as described above.~~

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12	Outpatient Hospital Reimbursement Method	Except as otherwise provided in this Manual, the MRA for outpatient hospital services must ~~will~~ be determined as follows ~~reimbursed~~: • According to an agreed upon contract price; • The Base Rate from Appendix B for procedure codes ~~services~~ that are not scheduled outpatient surgery multiplied by the geographic modifier listed for the county of the location of service from Appendix A ~~(see reimbursement example in the note below)~~; or • The Base Rate from Appendix B.1 multiplied by the geographic modifier listed for the county of the location of service from Appendix A for procedure codes not listed in Appendix B. ~~• If the applicable CPT® or HCPCS Level II® code is not listed in Appendix B, 75% of the hospital's usual and customary charges; or~~ ~~• If the CPT® or HCPCS Level II® code is identified as an unlisted procedure in the CPT® or HCPCS Level II® manual, the CPT® or HCPCS Level II® code will be priced by the carrier as "By Report"; or~~ ~~• According to an agreed upon contract between the hospital and the carrier/employer.~~ ~~**Note:** See **Definitions** in this Manual for the definition of "By Report".~~ Reimbursement example for service in Orange County: **Example 1 (CPT® code listed in Appendix B)**: The Base Rate for CPT® code 64480 listed in Appendix B is $375.00 and the geographic modifier for Orange County from Appendix A is 1.0123. Therefore, the MRA would be $379.61 ($375.00 x 1.0123 = $379.61). **Example 2 (CPT® code not listed in Appendix B)**: The Base Rate for CPT® code 64484, identified in the CPT code range 64400-64999 listed in Appendix B.1 is $1,654.00. The geographic modifier for Orange County from Appendix A is 1.0123. Therefore, the MRA would be $1,674.34 ($1,654.00 x 1.0123 = $1,674.34).
~~12~~	~~Unlisted Procedure or Service Paid By Report~~	~~Reimbursement for an unlisted procedure or service, as defined in the CPT® or HCPCS Level II® manual, will be determined by the carrier.~~ ~~Payment will be based on the hospital's documentation containing the complete description of the service(s) or procedure(s) performed, the cost of any additional supplies, 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® or HCPCS Level II® manual;~~ ~~• Make reimbursement decisions based on the hospital documentation, medical bills, comparison data, services provided, supplies used, equipment provided, and peer physician recommendations; and~~ ~~• Reimburse all work-related and medically necessary services provided in a documented medical or dental emergency.~~

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~~12~~	~~Unlisted Procedure or Service Paid By Report~~ (continued…)	~~**Note:** When an inpatient admission occurs following emergency room services or immediately subsequent to other outpatient services, reimbursement for the hospital services will be subject to the provisions for inpatient services in this Manual.~~ ~~Geographically modified reimbursement example for service in Broward County:~~ ~~CPT® code 12013 in Appendix B is listed as $487.00 and the geographic modifier for Broward County from Appendix A is 1.1302.~~ ~~Therefore, reimbursement would be $550.41 ($487.00 x 1.1302 = $550.41).~~
12	Scheduled Surgical Services	Except as otherwise provided in this Manual, the MRA for scheduled surgical services must ~~will~~ be determined as follows ~~reimbursed~~: • According to an agreed upon contract price; • The Base Rate from Appendix C for ~~the~~ procedures codes performed multiplied by the geographic modifier listed for the county of the location of service from Appendix A ~~(see reimbursement example in the note below)~~; or • The Base Rate from Appendix C.1 multiplied by the geographic modifier listed for the county of the location of service from Appendix A for procedure codes not listed in Appendix C. ~~• If the applicable CPT® or HCPCS Level II® code is not listed in Appendix C, 60% of the hospital's usual and customary charges; or~~ ~~• If the CPT® or HCPCS Level II® code is identified as an unlisted procedure or service in the CPT® or HCPCS Level II® manual, the CPT® or HCPCS Level II® code will be priced by the carrier as "By Report"; or~~ ~~• According to an agreed upon contract between the hospital and the carrier/employer.~~ ~~**Note:** See **Definitions** in this Manual for the definition of "By Report".~~ **Note:** ~~Geographically modified~~ Rreimbursement example for service in Pinellas ~~Broward~~ County: **Example 1 (CPT® code listed in Appendix C)**: The Base Rate for CPT® code 29805 ~~29880~~ listed in Appendix C is ~~listed as~~ $6,334.00 ~~5,815.00~~ and the geographic modifier for Pinellas ~~Broward~~ County from Appendix A is 1.0260 ~~1.1302~~. Therefore, the MRA ~~reimbursement~~ would be $6,498.68 ~~6,572.11~~ ($6,334.00 ~~5,815.00~~ x 1.0260 ~~1.1302~~) = $6,498.68 ~~6,572.11~~). **Example 2 (CPT® code not listed in Appendix C)**: The Base Rate for CPT® code 29871, identified in the CPT® code range 29800-29999 listed in Appendix C.1 is $5,096.00. The geographic modifier for Pinellas County from Appendix A is 1.0260. Therefore, the MRA would be $5,228.50 ($5,096.00 x 1.0260) = $5,228.50.

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13	Services in Conjunction with a Surgical Procedure	Radiology and clinical laboratory services that are provided within three days prior to a scheduled outpatient surgery are deemed services provided "in conjunction with a surgical procedure". These services are reimbursed according to the reimbursement method for **Scheduled Surgical Services** ~~using Appendix C~~.
13	Determining Surgical ~~vs. Non-Surgical~~ Services	Determination of whether outpatient services are surgical ~~or non-surgical~~ must be pursuant to the CPT® code(s) reported by the hospital on the hospital billing form pursuant to Rule 69L-7.501, F.A.C. Reimbursement as a surgical ~~code~~ procedure applies if the CPT® code(s) reported on the hospital billing form are ~~is~~ within the range of 10021-69990, *except* when the surgical procedure code within the range of 10021-69990 is performed for: • V~~v~~enipuncture; to administer parenteral medication(s); • I~~i~~n conjunction with an invasive medical, therapeutic, or diagnostic procedure~~,~~; • Any procedure or service ~~such as that~~ requiring placement of a cannula or catheter; or • Procedures that are ~~in conjunction with an~~ invasive radiology or laboratory service~~s~~ that include~~s~~ injection of diagnostic or therapeutic substance(s), with or without contrast media. Hospitals must make written entry on the hospital billing form to identify whether an outpatient surgery was scheduled or unscheduled. The hospital must enter "Scheduled" or "Unscheduled" in Form Locator 80. For the purpose of determining reimbursement, the procedures codes subject to the preceding exceptions must ~~will~~ be considered n~~N~~on-s~~S~~urgical services and must be reimbursed consistent with the **Outpatient Hospital Reimbursement Method** ~~using Appendix B~~. ~~CPT only copyright 2017 American Medical Association. All rights reserved.~~
13	Billing for Surgical Implant(s) and Associated Disposable Instrumentation	All hospitals must bill Surgical Implant(s) and Associated Disposable Instrumentation required for the Surgical Implant only using Revenue Code 0278. Surgical Implant(s) and Associated Disposable Instrumentation must be itemized separately from the surgical procedure code(s). Eligible items are reimbursed in addition to the primary procedure. In order to receive reimbursement for Surgical Implant(s) and their associated costs, the hospital 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. • 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. • 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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13	Surgical Implant Reimbursement	Reimbursement for Surgical Implants required during an outpatient hospitalization must be made according to a geographical, wage-adjustment factor applied to the documented acquisition invoice cost multiplied by two. The MRA is determined as follows: • An agreed upon contract price; or • For Scheduled Surgeries; 60% of the documented acquisition invoice cost of the Surgical Implants utilized, multiplied by two, multiplied by Medicare's geographic wage adjustment factor from Appendix A for the county where the service is performed; or • For all other surgeries and medical procedures; 75% of the documented acquisition invoice cost of the Surgical Implants utilized, multiplied by two, multiplied by Medicare's geographic wage adjustment factor from Appendix A for the county where the service is performed. Reimbursement example for service in St. Lucie County: **Example 1 (Scheduled Surgical Implant procedure):** The acquisition invoice cost of the Surgical Implant(s) is $350.00. The geographic wage adjustment factor for St. Lucie County is 1.0531. Therefore, the MRA would be $442.30 ($350.00 x 2) x (1.0531) x (.60) = $442.30. **Example 2 (All other surgeries and medical procedures):** The acquisition invoice cost of the Surgical Implant(s) is $625.00. The geographic wage adjustment factor for St. Lucie County is 1.0531. Therefore, the MRA would be $987.28 ($625.00 x 2) x (1.0531) x (.75) = $987.28. The hospital must be reimbursed for the Associated Disposable Instrumentation required for the implantation of the Surgical Implant(s): • According to an agreed upon contract price; or • Twenty percent (20%) over the acquisition invoice cost when documentation is provided by the hospital. Associated Disposable Instrumentation is only reimbursed for those procedures requiring Surgical Implants. The hospital must be reimbursed for Shipping and Handling at the actual cost to the hospital listed on the acquisition invoice. No reimbursement is made for sales tax. ~~Reimbursement for Surgical Implant(s), also referred to as "Other Implant" in the UB-04 Manual, and Associated Disposable Instrumentation required during outpatient surgery must be billed using Revenue Code 0278.~~ • ~~For those utilized during unscheduled surgeries, Surgical Implants and Associated Disposable Instrumentation shall be reimbursed seventy-five percent (75%) of the hospital's usual and customary charge; or~~ • ~~For those utilized during scheduled surgeries, Surgical Implants and Associated Disposable Instrumentation shall be reimbursed sixty percent (60%) of the hospital's usual and customary charge; or~~

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13	Surgical Implant Reimbursement (continued…)	~~• According to an agreed upon contract between the hospital and the carrier/employer.~~ ~~The Hospital must submit to the carrier copies of the implant log, found in the operative records, and documentation of the Associated Disposable Instrumentation utilized for implantation. The documentation must list the items that substantiate the utilization of the Surgical Implant(s) and Associated Disposable Instrumentation billed.~~ ~~In order to receive reimbursement for Surgical Implant(s) and associated costs, the hospital must either:~~ ~~• The hospital must submit to the carrier copies of the implant log, found in the operative records, and documentation of the Associated Disposable Instrumentation used for implantation substantiating the utilization of the Surgical Implant(s) and Associated Disposable Instrumentation billed.~~
~~13~~	~~Undocumented Charges for Surgical Implant(s)~~	~~Surgical Implant(s) and Associated Disposable Instrumentation will be adjusted or disallowed when submitted without implant logs or documentation listing the Associated Disposable Instrumentation used for implantation.~~ ~~**Note:** Since there are no CPT® or HCPCS Level II® codes for Surgical Implants and Associated Disposable Instrumentation incorporated into Appendices B or C, pursuant to the description of usual and customary charges provided in the **Introduction** of this, these items are reimbursed at the applicable percentage of the hospital's usual and customary charge.~~
14	Determining Surgical Implant Acquisition Cost	When determining the acquisition invoice cost of the Surgical Implant(s), the hospital must subtract any and all price reductions, offsets, discounts, adjustments, and/or refunds which accrue to, or are factored into, the final net cost to the hospital, only if they appear on the acquisition invoice, before increasing the invoice amount by the percentage factors described under **Surgical Implant Reimbursement**.
14	Reimbursement for Terminated Procedures	Reimbursement must 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 be made consistent with the following requirements: 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 must be: • According to an agreed upon contract price; or • Fifty percent (50%) of the MRA listed in this Manual. Bill using modifier 73. If a procedure is terminated due to a medical complication that arises causing the procedure to be terminated after induction of anesthesia. Reimbursement must be: • According to an agreed upon contract price; or • The MRA for the comprehensive procedure code if listed in this Manual. Bill using modifier 74.

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14	~~Outpatient~~ Observation	Observation is an outpatient hospital service regardless of the location of the injured worker within the facility. ~~Observation services must be billed using Revenue Code 0762 in accordance with Rule Chapter 69L-7, F.A.C.~~ Observation status requires an order from the physician. Observation services must be billed as an hourly service using the appropriate procedure code with Revenue Code 0762. Observation services must ~~will~~ be reimbursed: • According to an agreed upon contract price; or • Using the **Outpatient Hospital Reimbursement Method** according to the primary reason the injured worker receives care in the outpatient hospital setting ~~(i.e. scheduled surgical care, emergency room services, or non-scheduled surgical services)~~. If ~~an~~ Observation services are ~~is~~ subsequently followed by an admission to the inpatient hospital, a written physician's order is required. The entire hospital encounter must ~~then~~ be billed and reimbursed as an inpatient hospital admission ~~bill type and reimbursed according to the guidelines of this Manual~~. **Note:** Observation services for each hour in excess of the 23rd hour is ~~are~~ not reimbursable pursuant ~~according~~ to section 440.13(12)(a), F.S.
15	Determining Reimbursement for Outpatient Therapies	Reimbursement for therapy services must be: • According to an agreed upon contract price; or • The MRA according to Rule 69L-7.020, F.A.C. Carriers must ~~will~~ only adjust outpatient physical therapy, occupational therapy, and speech therapy services identified on the hospital billing form in accordance with Rule 69L-7.020, F.A.C., which are billed using the following Revenue Codes: 0420-0429, 0430-0439, 0440-0449, and 0930-0932. When reimbursement is according to Rule 69L-7.020, F.A.C, reimbursement is determined by the following instructions ~~To determine reimbursement~~: • Carriers must ~~will~~ determine the non-hospital provider MRA that applies based on the W~~w~~orkers' C~~c~~ompensation unique code, the CPT® code, or the HCPCS Level II® code reported by the hospital on the hospital billing form. • Carriers must ~~will~~ determine the number of units of physical, occupational, or speech therapy services reported by the hospital for each procedure code. • Carriers must ~~will~~ multiply the non-hospital provider MRA in Part C of the Florida Workers' Compensation Health Care Provider Reimbursement Manual, by the units of service to determine the MRA for the specific physical, occupational, or speech therapy services. **Note:** The provisions of the Physical Medicine and Rehabilitation Services section of the Florida Workers' Compensation Health Care Provider Reimbursement Manual must ~~will~~ also apply to outpatient hospital therapy reimbursement and are hereby incorporated pursuant to Rule 69L-7.020, F.A.C.

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15	Scheduled, Non-Emergency Clinical Laboratory, and Radiology Services	Scheduled, non-emergency clinical laboratory, and radiology services must ~~will~~ be reimbursed according to the schedule of MRAs which applies to non-hospital providers found in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, incorporated in Rule 69L-7.020, F.A.C. The General Instructions, of the Florida Workers' Compensation Health Care Provider Reimbursement Manual provides information for determining the applicable non-hospital provider MRA.
15	Determining Reimbursement for Scheduled, Non-Emergency Clinical Laboratory, and Radiology Services	Reimbursement for scheduled, non-emergency clinical laboratory and radiology services must be: • According to an agreed upon contract price; or • The MRA according to Rule 69L-7.020, F.A.C. Carriers must ~~will~~ adjust only clinical laboratory and radiology outpatient services, identified on the hospital billing form, in accordance with Rule 69L-7.020, F.A.C., using the following Revenue Codes: 0300-0309, 0320-0329, 0330-0339, 0340-0349, 0350-0359, 0400-0409, and 0610-0619. When reimbursement is according to Rule 69L-7.020, F.A.C, reimbursement is determined by the following instructions ~~To determine reimbursement~~: • Carriers must ~~will~~ determine the non-hospital provider MRA in Part C of the Florida Workers' Compensation Health Care Provider Reimbursement Manual that applies to the technical component (TC) of the CPT® code or HCPCS Level II® code reported by the hospital on the hospital billing form. • Carriers must ~~will~~ determine the number of units of service reported by the hospital on the hospital billing form. • Carriers must ~~will~~ multiply the MRA determined above by the units of service to determine the outpatient hospital reimbursement for the specific radiology or clinical laboratory services. **Note:** When clinical laboratory or radiology services are provided within three days prior to the date of scheduled surgery, reimbursement is made pursuant to the reimbursement method for **Scheduled Surgical Services** ~~using Appendix C~~. ~~CPT only copyright 2017 American Medical Association. All rights reserved.~~

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16	Federal Hospitals	Federal hospitals are not subject to the MRAs adopted by the Three-Member Panel and set forth in this Manual~~; and Federal hospitals~~ These hospitals may use their own customary billing form instead of the forms required by Rule Chapter 69L-7, F.A.C.
16	Out-of-State Hospitals	Hospital services provided outside of the state of Florida must ~~will~~ be reimbursed according to an ~~the amount~~ agreed upon contract price ~~by the hospital and the carrier~~ pursuant to obtaining authorization as required by this Manual. If no amount has been pre-approved, the hospital must ~~will~~ be reimbursed the greater of: • The amount of reimbursement established under the Workers' Compensation statute where the hospital is located; or • ~~The MRA as determined using this Manual, including the limitations on reimbursement for radiology, clinical laboratory, and physical, occupational, and speech therapies.~~ • The inpatient per diem rate or the outpatient base rate, as applicable, as listed in this Manual. The limitations on reimbursement for radiology, clinical laboratory, and physical, occupational, and speech therapies apply.
17	Disallowance and Adjustment of Itemized Charges	~~Except when reimbursement is according to the per diem allowances set forth in this Manual,~~ The carrier must disallow or adjust reimbursement when: • ~~for any C~~charges are not documented in the patient's medical record; • Charges are not consistent with the hospital's Charge Master; or • Charges ~~are~~ for services, treatment, or supplies ~~that~~ are not medically necessary; except when the services are required t~~T~~o stabilize or maintain the patient's medical status in order to treat the patient's compensable injury, or f~~F~~or treatment of the patient's compensable injury or condition.

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17	Minimum Partial Payment Required	Whenever ~~At any time when~~ a carrier denies, disallows, or adjusts payment for hospital charges, in accordance with the time limitations and coding requirements established by statute and by rule, the carrier must remit a minimum partial payment of the hospital's charges, which payment shall accompany the Explanation of Bill Review (EOBR). The minimum partial payment required shall be determined as follows: • **Per Diem Payments:** The carrier must remit minimum partial payment for ~~total charges less than $69,468.00 pursuant to~~ the applicable per diem rate for each inpatient day for which the hospital obtained pre-certification in accordance with this Manual and for which there is no dispute as to the medical necessity of the hospital pre-certified day(s). • ~~**Stop-Loss Payments:** The carrier must remit minimum partial payment pursuant to the greater of:~~ ~~a. The applicable per diem rate for each inpatient day for which the hospital obtained pre-certification in accordance with this Manual, and for which there is no dispute as to the medical necessity of the hospital day, plus payment for any itemized charges that are not denied, disallowed, or adjusted; or~~ ~~b. The applicable reimbursement for each of the itemized charges that are not denied, disallowed, or adjusted.~~ ~~Subject to any minimum partial payments required herein, the carrier must deny, disallow, or adjust payment for charges included in the Total Gross Charge After Implant Carve-Out that do not correspond to the hospital's itemized statement or are for undocumented or medically unnecessary services or supplies as determined in accordance with this Manual.~~ ~~If adjustments to the Total Gross Charge After Implant Carve-Out reduces the Total Gross Charge After Implant Carve-Out to $69,468.00 or less, minimum partial payment for the Total Gross Charge After Implant Carve-Out must be pursuant to the applicable Per Diem Schedule.~~ • **Outpatient Payments:** The carrier must remit minimum partial payment according to the applicable reimbursement for each CPT® or HCPCS Level II® or Wworkers' Ccompensation unique procedure codes billed for each of the itemized charges that are not denied, disallowed, or adjusted.

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~~17~~	~~Disputing Reimbursement~~	~~A contested disallowance or adjustment of payment may be resolved by petitioning the Department within forty-five (45) calendar days of receipt of a disallowance or adjustment of payment from the carrier pursuant to section 440.13(7), F.S.~~
18	~~Hospital~~ Charge Master	The hospital must produce, ~~either by paper or electronically,~~ or make available for on-site review, when requested by the carrier or its designee ~~pursuant to negotiations between the hospital and carrier or its designee regarding a proposed agreement~~, the relevant portions of the hospital's Charge Master as it existed on the date(s) of service for the treatment of an injured worker. The carrier may elect to request copies <u>electronically or by paper</u>, subject to copying charges pursuant to this Manual, of relevant portions of a hospital's Charge Master and any medical records for in-house desk audit or review; or to conduct an audit or review of original documents on-site at the hospital to verify the accuracy of a hospital's charges, billing practices, or medical necessity and compensability of charges for medical services or supplies. The hospital must produce copies of the relevant portions of the hospital's Charge Master and any medical records subject to copying charges according to this Manual, or make the original documents available on-site, within thirty (30) calendar days of receipt of the written request from either the ~~Department~~ <u>Division</u> or a carrier or its designee, as part of an audit or review according to this Manual and pursuant to section 440.13(12)(d), F.S.
18	Exit Interview	At the conclusion of the on-site review of documentation, an exit interview <u>may</u> ~~will~~ be conducted by the carrier, if requested by the hospital, concerning the carrier's findings. ~~Neither a request nor completion of an on-site record review or audit will toll the timeframe for petitioning the Division for resolution of a reimbursement dispute. See subsection 69L-31.008(5), F.A.C.~~

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19	~~Additional~~ Billing Requirements	In addition to submitting Form DWC-90 a hospital must: • Attach an itemized statement with charges based on the facility's Charge Master; and • Submit all documentation <u>required by this Manual and</u> ~~or certification~~, requested by the carrier ~~in writing, at the time of authorization~~; and • Bill all professional services provided by hospital-employed physicians, physician assistants, advanced registered nurse practitioners, anesthesia assistants, or registered nurse first assistants on the Form DFS-F5-DWC-9; <u>and</u> ~~• For inpatient hospital claims, the manufacturer's acquisition invoices reflecting the hospital's actual cost for the Surgical Implants, Associated Disposable Instrumentation, and Shipping and Handling must accompany the bill for the reimbursement of each component. All manufacturer's acquisition invoices must clearly identify the items that are used during surgery, e.g.,Surgical Implants, Associated Disposable Instrumentation, and Shipping and Handling.~~ ~~• For inpatient hospital claims, if a hospital 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).~~ ~~• When certifying for reimbursement of the Associated Disposable Instrumentation, documentation must be maintained by the hospital supporting the Associated Disposable Instrumentation was received on the same manufacturer's acquisition invoice as the Surgical Implant.~~ ~~• For inpatient and outpatient hospital claims, the Surgical Implant Log and documentation of the Associated Disposable Instrumentation utilized for implantation are required for reimbursement.~~ ~~• When billing Associated Disposable Instrumentation, the Associated Disposable Instrumentation must be listed on the same manufacturer's acquisition invoice as the Surgical Implant(s).~~ • Utilize CPT®, HCPCS Level II®, or <u>W</u>~~w~~orkers' <u>C</u>~~c~~ompensation unique codes or modifiers referenced in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, adopted in Rule 69L-7.020, F.A.C., when entering procedure codes and modifiers in Form Locator 44 on Form DWC-90~~.~~<u>; and</u> • <u>Bill using the appropriate Revenue Center code in Form Locator 42. All outpatient hospital bills must have a Revenue Center code and the appropriate HCPCS Level II® or CPT® code in Form Locator 44, where required pursuant to the UB-04 Manual, unless a Revenue Center code is billed that does not require a HCPCS Level II® procedure code.</u>

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~~19~~	~~Outpatient Hospital Billing Requirement~~	~~Hospitals must bill using the appropriate Revenue Center code in Form Locator 42. All outpatient hospital bills must have a Revenue Center code and the appropriate HCPCS Level II® or CPT® code in Form Locator 44, where required pursuant to the UB-04 Manual, unless a Revenue Center code is billed that does not require a HCPCS Level II® procedure code.~~
19	~~Billing~~ Form Completion Instructions for the DWC-90	~~Billing~~ Form Completion Instructions for the DWC-90 are available on the DWC website (https://www.myfloridacfo.com/Division/WC~~wc~~/) under Rule Chapter 69L-7, F.A.C.
66	Definitions	(1) **Admission** means an injured worker that enters a hospital for medical services when, based on the written order from the treating physician, the injured worker will require hospital ~~specific~~ services for medical care. For purposes of reimbursement, an injured worker is only admitted as an ~~either~~: • Inpatient, or • Outpatient; (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 neurostimulators. 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. ~~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).~~ ~~(3) **Authorization** means the approval given to a health care provider by the carrier, self-insured employer, or entity representing the carrier or self-insured employer for the provision of specific medical services to an injured worker.~~ ~~(4) **By Report** means a reimbursement allowance made by the carrier based on specific documentation submitted to the carrier containing information on the complete description of the services, procedures, medical necessity, prevailing charges, and reimbursement for clinically similar procedures or cost of the services or supplies.~~ ~~(5) **Certification** means the dollar amount of Surgical Implants, and Associated Disposable Instrumentation, and any Shipping and Handling costs the hospital is declaring for reimbursement in Form Locator 80 on the billing form. This requested reimbursement for the Surgical Implant(s) billed under Revenue Code 0278 does not exceed sixty percent (60%) 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, and the shipping and handling does not exceed invoice cost.~~

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66	Definitions (continued…)	(~~36~~) **Charge Master** means a comprehensive listing that documents the facility's charge for all the goods and services for which the facility maintains a separate charge, with the facility's charge for each of the goods and services, by description, unit size, unit price and all identifying information maintained by the hospital, regardless of payer type. The Charge Master must be maintained, and relevant portions produced for those charges determined compensable by the carrier for an injured employee when requested for the purpose of verifying charges pursuant to section 440.13(12)(d), F.S. (4) **Coronary Care** are identified using revenue codes 0210-0219, in Form Locator 42 of DWC-90 claim form. (~~57~~) **Division** means the Division of Workers' Compensation of the Department of Financial Services, as defined in section 440.02(14), F.S. (~~68~~) **Health Care Provider** means a provider as defined in section 440.13(1)(g), F.S. (~~79~~) **Hospital** means a health care facility licensed under S~~s~~ection 395.003, F.S. (8~~10~~) **Inpatient** means an injured worker who is admitted to a hospital for services when, based on the written admitting order from the physician that specifies inpatient status, the injured worker will require at least a 24-hour stay as an inpatient status. (9) **Intensive Care** are identified using revenue codes 0200-0209, in Form Locator 42 of the DWC-90 claim form. (10~~11~~) **Itemized Statement** means a detailed listing of hospital services and supplies, as described in S~~s~~ection 395.301, F.S., provided to an injured worker during an episode of care. (11~~12~~) **Medical Record** means patient records maintained in accordance with the form and content required under S~~s~~ections 395.3015, 395.302, and 395.3025, F.S. (12~~13~~) **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 they relate to the itemized statement for a specific bill. (13~~14~~) **Observation Services** means those services furnished on a limited basis on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, regardless of the location in the hospital where the injured worker is placed. Observation Services require a written order from the attending physician and must be determined by the attending physician to be medically necessary to evaluate a condition of a patient whose status is outpatient and to determine the need for a possible admission to the hospital as an inpatient. (14~~15~~) **Outpatient** means an injured worker who, with the written order of the physician, is admitted to the hospital as an outpatient for diagnosis or treatment. (15~~16~~) **Per Diem** means a reimbursement allowance based on a fixed rate per calendar day which is inclusive of all services ~~rather than on a charge-by-charge basis~~. (16~~17~~) **Physician** means a physician as defined in section 440.13(1)(p), F.S.

Page #	Section/Paragraph Titles	Text Change
67	Definitions (continued…)	~~(18) **Stop-Loss Reimbursement** means a reimbursement methodology based on billed charges once reaching a specified amount that is used in place of, and not in addition to, per diem reimbursement for an inpatient admission to an acute care hospital or a Trauma Center.~~ (17) **Surgical Implant** means, any single-use item that is surgically inserted and meets the definition of medically necessary, pursuant to section 440.13(1)(k), F.S., which the physician does not specify to be removed in less than six weeks. Examples of such items are: 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. (18) **Surgical Stay** means an admission where the services on the hospital bill are identified using revenue code(s): 0360, 0361, 0362, 0367, or 0369, in conjunction with revenue code(s) 0370 or 0379, in Form Locator 42 of the DWC-90 claim form. The surgical procedure must be substantiated by the operative report and the anesthesia report. ~~(19) **Surgical Stay** means any admission where the services rendered are surgical (operative) based on the presence of any of the following revenue code(s) 0360, 0361, or 0369, in conjunction with revenue code(s) 0370 or 0379, for the same date(s) of service on the hospital bill, in Form Locator 42. The operative status must be substantiated by the operative report and the anesthesia report for the services provided to the injured worker.~~ ~~(20) **Total Gross Charge** means the sum of all charges entered on the hospital billing form during the covered period identified on the hospital bill.~~ ~~(21) **Total Gross Charge After Implant Carve-Out** means the Total Gross Charge identified on the hospital bill less the sum of all charges for Surgical Implants billed pursuant to Rule Chapter 69L-7, F.A.C.~~ ~~(22) **Trauma Center** means a hospital approved for certification as a trauma center pursuant to section 395.401, F.S.~~