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FLORIDA WORKERS' COMPENSATION
REIMBURSEMENT MANUAL FOR HOSPITALS

2006 Edition

Florida Department of Financial Services
Division of Workers' Compensation
for incorporation by reference into
Rule 69L-7.501, Florida Administrative Code

TABLE OF CONTENTS

Section	Title	Page
I	Introduction and Purpose of Manual	3
II	Reimbursement for Federal and Out-of-State-Hospitals	3
III	Publications Incorporated by Reference	4
IV	Billing	4
	A. Rule 69L-7.602, F.A.C.	
	B. Surgical Implants	
V	Authorization	5
VI	Pre-Certification of Estimated Length of Stay	6
VII	Medical Record Maintenance, Release and Copy Charges	6
	A. Medical Records	
	B. Mandatory Disclosure	
	C. Copying Charges for Medical Records	
VIII	Inpatient Reimbursement and Per Diem Schedule	8
	A. Reported Charges	
	B. Charges for Surgical Implant(s)	
	C. Total Gross Charges After Implant Carve-Out	
	D. Per Diem Schedule	
	E. Stop-Loss Reimbursement	
IX	Surgical Implants	11
	A. Cost Formula	
	B. Billing and Identification of Surgical Implant Charges	
	C. Request for Reimbursement	
	D. Certification of Implant Amount for Reimbursement	
	E. Verification of Surgical Implant Costs and Charges	

X	Outpatient Reimbursement	13
	A. Reimbursement Amount	
	B. Scheduled Surgery	
	C. Observation Status	
	D. Scheduled Non-Emergency Radiology and Clinical Laboratory Services	
	E. Physical, Occupational and Speech Therapies	
XI	Disallowed, Denied and Disputed Charges	16
	A. Reimbursement for Services Unrelated to the Compensable Injury	
	B. Physician Services	
	C. Disallowance and Adjustment of Itemized Charges	
	D. Timely Payment and Notice of Adjustment, Disallowance or Denial	
	E. Minimum Partial Payment Required	
XII	Hospital Charge Master and Medical Record Review or Audit	18

Appendices

A	Definitions	20
B	Rule 69L-7.501, Florida Administrative Code	23

SECTION I: INTRODUCTION AND PURPOSE OF MANUAL

This Manual is promulgated by the Department of Financial Services, Division of Workers' Compensation (Division), for incorporation by reference into the Florida Workers' Compensation Reimbursement Manual for Hospitals Rule, rule 69L-7.501, Florida Administrative Code (F.A.C.).

The Manual contains the Maximum Reimbursement Allowances (MRA) determined by the Three Member Panel, pursuant to s. 440.13(12), Florida Statutes (F.S.), and establishes policy, procedures, principles and standards for implementing statutory provisions regarding reimbursement for medically necessary services and supplies provided to injured workers in a hospital setting. The policy, procedures, principles and standards in this Manual are in addition to the requirements established by the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, rule 69L-7.602, F.A.C.

The administrative rules and the Manual may be obtained free of charge online at <http://www.fldfs.com/wc>, or purchased in hard copy according to the online instructions provided at the web site, or directly from the Department of Financial Services, Document Processing Section, at 200 East Gaines Street, Tallahassee, Florida 32399-0311.

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

SECTION II: REIMBURSEMENT FOR FEDERAL AND OUT-OF-STATE HOSPITALS

When providing services to injured workers entitled to medical benefits under the Florida Workers' Compensation Law, both federal and out-of-state hospitals shall comply with the Division's rule(s), including the requirements and procedures established in this Manual, except that:

A. Federal Hospitals.

1. Are not subject to the MRA adopted by the Three Member Panel and set forth in Sections VIII, IX, and X of the Manual; and

2. May use their own billing form instead of the form required by rule 69L-7.602, F.A.C.

B. Out-of-State Hospitals.

Hospital services provided outside of the state of Florida shall be reimbursed the amount agreed upon by the hospital and the insurer pursuant to obtaining authorization as required by Section V of this Manual, or if no amount has been pre-approved, the hospital shall be reimbursed the greater of:

1. The amount of reimbursement established under the workers' compensation statute of the jurisdiction where the hospital is located; or
2. The MRA as determined using this Manual, including the limitations on reimbursement for radiology, clinical laboratory, and physical, occupational and speech therapies which are determined according to the Florida Workers' Compensation Health Care Provider Reimbursement Manual incorporated by reference in rules 69L-7.020 and 69L-7.501, F.A.C.

SECTION III: PUBLICATIONS INCORPORATED BY REFERENCE

In addition to this Manual, the Florida Workers' Compensation Reimbursement Manual for Hospitals Rule, rule 69L-7.501, F.A.C., also incorporates the following publications by reference.

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

SECTION IV: BILLING

A. Rule 69L-7.602, F.A.C.

Hospitals and insurers shall comply with the requirements of the Workers' Compensation Medical Services Billing, Filing, and Reporting Rule, rule 69L-7.602, F. A. C.

B. Surgical Implants.

Additional billing, reporting and documentation requirements specific to requesting reimbursement for surgical implants when used in an inpatient hospital setting are set forth in Section IX of this Manual.

SECTION V: AUTHORIZATION

- A. A hospital shall obtain authorization from the insurer prior to providing any non-emergency medical treatment, care or attendance for a patient's work-related injury or condition.
- B. A hospital shall record the authorization in the injured employee's medical record or in the hospital's billing or financial record(s) and shall include:
 - 1. The date(s) on which authorization was requested and received;
 - 2. The name of the insurer or its designated entity, and the person authorizing the hospital services; and
 - 3. The estimated length of stay pre-certified for inpatient care, if any, pursuant to Section VI of this Manual.
- C. Emergency services and care, defined in s. 395.002, F.S., do not require authorization at the time they are rendered. However, when an emergency medical condition requires or results in an emergency hospital admission, the hospital shall notify the insurer by telephone within 24 hours of the admission, as required by s. 440.13(3)(b), F.S.
- D. When it is determined that an emergency medical condition, defined in s. 395.002, F.S., does not exist or no longer exists and only non-emergent follow-up examination or services are required or recommended, any related follow-up care or treatment or referral must be expressly authorized by the carrier prior to the provision of the additional treatment or care pursuant to s. 440.13(3) (c), F. S.

SECTION VI: PRE-CERTIFICATION OF ESTIMATED LENGTH OF STAY

When authorizing inpatient admissions, the insurer shall pre-certify the number of days of hospitalization for which reimbursement can be anticipated.

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

Medical record reviews to determine the medical necessity of hospital services pursuant to this Section may be done either concurrently, during the hospital stay, or retrospectively, after discharge. However, a retrospective medical record review shall not toll the 45 day time period established to pay, disallow, or deny the hospital bill pursuant s. 440.20(2)(b), F.S.

SECTION VII: MEDICAL RECORD MAINTENANCE, RELEASE AND COPY CHARGES

A. Medical Records.

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

B. Mandatory Disclosure.

Unless otherwise prohibited by law, and subject to the confidentiality requirements of state and federal law(s), upon request of the Division, Agency, Judge of Compensation Claims, employee, employer or carrier, hospitals shall produce any and all medical records, reports, and information of an injured employee relevant to the particular injury or illness for which compensability has been accepted or for which it is necessary to determine compensability as required pursuant to s. 440.13(4)(c), F.S.

C. Copying Charges for Medical Records.

1. Employee.

An injured employee or injured employee's attorney requesting copies of medical records shall reimburse the hospital for copying charges pursuant to s. 440.13(4)(b), F.S., and rule 69L-7.601, F.A.C. No other copy charges or search charges may be charged to the injured employee or the injured employee's attorney as part of the services provided to the injured employee by the hospital.

2. Insurer.

An insurer, employer or authorized representative requesting copies of medical records shall reimburse the hospital for copying charges pursuant to s. 395.3025, F.S.

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

The above charges apply to all copies of original documents requested by an insurer whether the request for the copies is made before services are rendered or after services are rendered. The above charges apply to all copies of original documents requested by an insurer whether the copies of documents are sent to the 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, or whether the request is made in the course of an on-site audit or medical record review, and whether the request for copies is for an entire document or for selected portion(s) of a document.

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

3. Division, Agency, or Judge of Compensation Claims.

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

SECTION VIII: INPATIENT REIMBURSEMENT AND PER DIEM SCHEDULE

A. Reported Charges.

Except as otherwise provided in this Manual, inpatient reimbursement shall be determined based on the charges entered by the billing hospital in the Form Locator on the hospital billing form as required by rule 69L-7.602, F.A.C. The reported charges shall correspond to the hospital's Charge Master.

B. Charges for Surgical Implant (s).

All hospitals shall report surgical implant charges according to the National Uniform Billing Committee Official UB-04 Data Specification Manual (National Uniform Billing Manual). For purposes of reimbursement under this Manual, surgical implant charges are those charges identified on the hospital billing form under Revenue Code 278. Reimbursement for surgical implants billed under Revenue Code 278, Surgical implant charges are those charges identified on the hospital billing form under the designated Revenue Code for implants. Reimbursement for surgical implants, when charged for inpatient hospital services and supplies, shall be determined separately pursuant to Section IX of this Manual.

C. Total Gross Charges After Implant Carve-Out.

Prior to calculating the amount of reimbursement for inpatient services pursuant to this Section, charges for surgical implant(s) shall be separated out from the total gross charges for which reimbursement is requested. The amount remaining after segregation of surgical implant charges, or the "Total Gross Charges After Implant Carve-Out," shall be reimbursed pursuant to the Per Diem Schedule or the Stop-Loss Method, if applicable.

D. Per Diem Schedule.

1. If the Total Gross Charges After Implant Carve-Out is \$51,400.00 or less, reimbursement shall be determined according to the following per diem allowances:
 - a. Inpatient services provided by hospital:
 - (1) Surgical stay: \$3,304.00 per day;
 - (2) Non-surgical stay: \$1,960.00 per day.
 - b. Inpatient services provided by a trauma center, licensed pursuant to s. 395.4025, F.S.:
 - (1) Surgical stay: \$3,305.00 per day;
 - (2) Non-surgical stay: \$1,986.00 per day.

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

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

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

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

- c. If, after segregation of the surgical implant charges, the charges for any day of hospitalization are less than the applicable per diem allowance established in this section, the hospital shall be reimbursed the per diem allowance for the day(s) rather than the lesser amount charged by the hospital.
2. The insurer shall not reimburse a per diem allowance for the day of discharge.
3. When a discharge occurs within 24 hours of admission to a hospital facility, reimbursement shall not exceed the applicable per diem allowance for a single day, unless the hospital indicates that the injured employee expired within the 24 hours. When discharge occurs within 24 hours of admission and the injured employee expired, the insurer shall reimburse the hospital either the applicable per diem allowance, or seventy-five percent (75%) of the hospital's charges, whichever is greater.
4. The insurer shall not disallow a per diem allowance for any day of an inpatient stay unless the documentation in the medical record does not support the medical necessity for each of the estimated number of days that were pre-certified, or the actual length of stay exceeds the estimated days that were pre-certified by the insurer and the medical record does not substantiate the medical necessity for the additional inpatient day(s).

E. Stop-Loss Reimbursement.

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

Subject to any minimum partial payments required by Section XI herein, ~~the~~ The insurer shall deny, disallow, or adjust payment for charges included in the Total Gross Charges After Implant Carve-Out that do not correspond to the hospital's Charge Master or are for undocumented or medically unnecessary services or supplies as determined in accordance with Sections XI and XII of this Manual. If any downward adjustment of the Total Gross Charges After Implant

Carve-Out, pursuant to Sections XI and XII of this Manual, reduces the Total Gross Charges After Implant Carve-Out to \$51,400.00 or less, reimbursement for the Total Gross Charges After Implant Carve-Out shall be pursuant to the applicable Per Diem Schedule.

SECTION IX: SURGICAL IMPLANTS

A. Cost Formula.

Requests for reimbursement for surgical implant(s) (also referred to as "implantables" by the National Florida Hospital Association Uniform Billing Manual) required during inpatient hospitalization billed under Revenue Code 278 shall not exceed sixty percent ~~shall be fifty percent (50%)~~ over the acquisition ~~invoice~~ cost(s) for the implant(s). Reimbursement for the associated disposable instrumentation required for the implantation of the surgical implant shall be twenty percent (20%) over the acquisition invoice cost, if the associated disposable instrumentation is received with the surgical implant and included on the acquisition invoice. Reimbursement for shipping and handling shall be at cost, if included on the acquisition invoice. This formula shall apply regardless of the amount of the charges reported by the billing hospital on the hospital billing form pursuant to rule 69L-7.602, F.A.C.

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

Reimbursement pursuant to this Section for surgical implant(s) and associated disposable instrumentation shall be in addition to reimbursement of the Total Gross Charges After Implant Carve-Out pursuant to Section VIII of this Manual.

B. Billing and Identification of Surgical Implant Charges.

Hospitals shall identify charges for surgical implant(s) and associated disposable instrumentation on the hospital billing form in the required Form Locator by using the designated revenue code in accordance and in compliance with the guidelines and definition of "Implantables" and "Examples of Other Implants (not all-inclusive)"

provided in the National Florida Hospital Association Uniform Billing Manual incorporated by reference into rule 69L-7.602, F.A.C.

C. Request for Reimbursement.

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

1. Submit a copy of the acquisition invoice(s) for purchase of the surgical implant(s) and associated disposable instrumentation as delineated in A above, plus the applicable shipping and handling charges, if any, to the insurer; or
2. Certify the amount being requested for reimbursement in accordance with this Section.

Charges billed under the surgical implant(s) revenue code(s) that are not accompanied by the invoice(s) for purchase of the surgical implant(s) and associated disposable instrumentation as delineated in A above or certification as provided in this Section shall constitute undocumented charges and shall not be reimbursed.

D. Certification of Implant Amount for Reimbursement.

Certification on a bill that the aggregate amount requested for reimbursement for the surgical implant(s) billed under Revenue Code 278 does not exceed in aggregate sixty percent (60%) over the acquisition costs as specified in Section IX: A. may be submitted as follows
~~Certification that the amount requested for reimbursement for the surgical implant(s) and associated disposable instrumentation has been determined in accordance with this Section may be submitted as follows:~~

1. By written statement accompanying the request for reimbursement for surgical implant (s);
2. Pursuant to prior written agreement between the billing hospital and the insurer regarding reimbursement for surgical implant(s); or
3. Electronically via the hospital billing form pursuant to this Section.

A hospital electing to submit certification of the implant reimbursement amount electronically via the hospital billing form shall place the amount in the Form Locator labeled for "Remarks" (last in the order of any required information in the Form Locator designated for this purpose pursuant to rule 69L-7.602, F.A.C.). The hospital shall enter "Implants" in the Form Locator immediately preceding the amount calculated according to the percentage factors times the acquisition invoice cost for the surgical implant(s) and associated disposable instrumentation as delineated in A above, plus applicable shipping and handling charges.

E. Verification of Surgical Implant Costs and Charges.

The hospital's certification of amounts requested for reimbursement pursuant to this Section, whether written, by prior agreement or electronically via the electronic hospital billing format, and the hospital's compliance with billing and revenue code specifications in accordance with the National FHA—Uniform Billing Manual incorporated by reference into rule 69L-7.602, F.A.C., shall be subject to verification through audit and medical record review pursuant to Section XII of this Manual.

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

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

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

SECTION X: OUTPATIENT REIMBURSEMENT

A. Reimbursement Amount.

Except as otherwise provided in this Section, hospital charges for

services and supplies provided on an outpatient basis shall be reimbursed at seventy-five percent (75%) of usual and customary charges for medically necessary services and supplies, and shall be subject to verification and adjustment in accordance with Sections XI and XII of this Manual.

However, when an admission occurs as the result of emergency room services, or immediately subsequent to other non-surgical outpatient services, reimbursement for the hospital services shall be subject to the provisions of Section VIII of this manual.

B. Scheduled Surgery.

Hospital charges for scheduled outpatient surgery shall be reimbursed ~~sixty~~60 percent (60%) of usual and customary charges and shall include all charges for radiology and clinical laboratory services when performed no more than three days prior to the date such surgery is performed ~~on the same date as the surgery~~.

Hospitals shall make written entry on the hospital billing form to identify whether an outpatient surgery was scheduled or unscheduled, in accordance with rule 69L-7.602, F.A.C.

Determination of whether outpatient services were surgical or non-surgical shall be pursuant to the CPT® code(s) reported by the hospital on the hospital billing form pursuant to rule 69L-7.602, F.A.C.

Reimbursement as a surgical procedure applies if the CPT® code reported on the hospital billing form is within the range of 10021 – 69990, except when the surgical procedure code within the range of 10021 – 69990 is performed for venipuncture or to administer parenteral medication(s), in conjunction with an invasive medical therapeutic or diagnostic procedure such as that requiring placement of a cannula or catheter, or in conjunction with an invasive radiology or laboratory service that includes injection of diagnostic or therapeutic substance(s), with or without contrast media. For the purpose of determining reimbursement, surgical procedure codes subject to the preceding exceptions shall be considered non-surgical services and subject to the reimbursement provision in A above.

Reimbursement for a scheduled outpatient surgery that results in the admission of the injured employee to the hospital within 24 hours of the scheduled outpatient surgery shall be subject to the

reimbursement provisions of Section VIII of this manual.

C. Observation Status.

Outpatient observation room services shall be billed under revenue code 0762 on the hospital billing form in accordance with rule 69L-7.602, F.A.C. Outpatient observation room services for beyond 23 hours shall be deemed services that are not covered for reimbursement pursuant to s. 440.13(12), F.S.

D. Scheduled Non-Emergency Radiology and Clinical Laboratory Services.

Scheduled non-emergency radiology and clinical laboratory services shall be reimbursed according to the schedule of MRAs which applies to non-hospital providers using the Florida Workers' Compensation Health Care Provider Reimbursement Manual (HCP RM), 2006 Edition, incorporated into rules 69L-7.020 and 69L-7.501, F.A.C. Section XI of the HCP RM (General Instructions and Part C) contains MRAs for radiology and clinical laboratory services, and Appendix E provides information for determining the applicable non-hospital provider locality. Radiology and clinical laboratory services that are provided on the same date as a scheduled outpatient surgery are deemed services provided "in conjunction with a surgical procedure" and are exempt from reimbursement provisions of this Section. (Refer to B above for reimbursement policy concerning radiology and clinical laboratory services performed on the same date as a scheduled outpatient surgery.)

1. Insurers shall adjust only clinical laboratory and radiology outpatient services identified on the hospital billing form in accordance with rule 69L-7.602, F.A.C., under the following revenue codes: 0300-0309, 0320-0329, 0330-0339, 0340-0349, 0350-0359, 0400-0409, and 0610-0619.
2. Insurers shall determine the non-hospital provider facility MRA in Section XI, Part C, that applies to the technical component of the CPT® or HCPCS code reported by the hospital on the hospital billing form in accordance with rule 69L-7.602, F.A.C.
3. Insurers shall determine the number of units of service reported by the hospital on the hospital billing form in accordance with rule 69L-7.602, F.A.C. for each CPT® or HCPCS code.

4. Insurers shall multiply the facility MRA determined in item (2) above by the units of service to determine the outpatient hospital MRA for the specific radiology or clinical laboratory services.

E. Physical, Occupational and Speech Therapies.

All outpatient physical, occupational and speech therapy services shall be reimbursed according to the schedule of MRAs which applies to non-hospital providers using the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2006 Edition (2006 HCP RM), incorporated into rules 69L-7.020 and 69L-7.501, F.A.C., and further explained herein. Section XI of the 2006 HCP RM, General Instructions and Part C contains MRAs for physical, occupational, and speech therapy services, and Appendix E provides information for determining the applicable non-hospital provider locality.

1. Insurers shall adjust only outpatient physical, occupational, and speech therapy services identified on the hospital billing form in accordance with rule 69L-7.602, F.A.C., under the following revenue codes: 0420-0429, 0430-0439, 0440-0449, 0930-0932.
2. Insurers shall determine the non-hospital provider facility MRA that applies based on the workers' compensation unique code, the CPT® code or the HCPCS code reported by the hospital on the hospital billing form in accordance with rule 69L-7.602, F.A.C.
3. Insurers shall determine the number of units of physical, occupational, or speech therapy services reported by the hospital for each procedure code on the hospital billing form in accordance with rule 69L-7.602, F.A.C.
4. Insurers shall multiply the facility MRA in Section XI, Part C, by the units of service to determine the outpatient hospital MRA for the specific physical, occupational or speech therapy services.
5. Provisions of Section VIII, Physical Medicine and Rehabilitation Services, of the 2006 HCP RM shall also apply to outpatient

therapy reimbursement and are hereby incorporated pursuant to rule 69L-7.020, F.A.C.

SECTION XI: DISALLOWED, DENIED AND DISPUTED CHARGES

A. Reimbursement for Services Unrelated to the Compensable Injury.

Insurers shall not reimburse hospital charges for services unrelated to the treatment or care of a compensable injury.

B. Physician Services.

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

C. Disallowance and Adjustment of Itemized Charges.

Except when reimbursement is pursuant to the per diem allowances set forth in Section VIII D of this Manual, the insurer shall disallow reimbursement for any charges that are not documented in the patient's medical record, are not consistent with the hospital's Charge Master, and/or are for services, treatment or supplies that are not medically necessary for treatment of the patient's compensable injury or condition.

D. Timely Payment and Notice of Adjustment, Disallowance or Denial.

Notwithstanding the insurer's right to disallow charges, the insurer shall comply with the Florida Workers' Compensation Medical Services Billing and Reporting Rule, rule 69L-7.602, and s. 440.20(2)(b), F.S., that require timely payment, adjustment, disallowance or denial of a hospital bill.

E. Minimum Partial Payment Required.

At any time when an insurer denies, disallows or adjusts payment for hospital charges in accordance with the time limitations and coding requirements established by rule 69L-7.602, F.A.C., and s. 440.20(2)(b), F.S., the insurer shall remit a minimum partial payment of the hospital's charges, which payment shall accompany the

Explanation of Bill Review (EOBR). The minimum partial payment required shall be determined as follows:

1. Inpatient Per Diem.

The insurer shall remit minimum partial payment pursuant to the applicable per diem rate for each inpatient day for which the hospital obtained pre-certification in accordance with Section VI of this Manual, and for which there is no dispute as to the medical necessity of the hospital day.

2. Outpatient and Inpatient Stop Loss Reimbursement.

The insurer shall 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 Section VI of 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; and
- b. The applicable reimbursement for each of the itemized charges that are not denied, disallowed or adjusted.

Upon receipt of a minimum partial payment from the insurer, the hospital may elect to contest the disallowance or adjustment pursuant to s. 440.13(7), F.S.

SECTION XII: HOSPITAL CHARGE MASTER AND MEDICAL RECORD REVIEW OR AUDIT

- A. The hospital shall produce, 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 hospital's Charge Master as it existed on any date within the most recent twelve (12) months.
- B. The carrier may elect to request copies, subject to copying charges pursuant to Section VII of this manual, of relevant portions of a hospital's Charge Master and any medical records for in-house desk audit or review or to conduct an audit or review of original

documents on-site at the hospital to verify the accuracy of a hospital's charges, billing practices, or medical necessity and compensability of charges for medical services or supplies.

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

At the conclusion of the on-site review of documentation, an exit interview shall 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 shall toll the time frame for petitioning the Agency for resolution of a reimbursement dispute pursuant to s. 440.13(7), F.S.

APPENDIX A

DEFINITIONS

APPENDIX A: Definitions.

- (1) "Admission" means an injured employee is admitted to a hospital for inpatient services when, based on the admission order from the treating physician, the injured employee will require an overnight stay for medical care.
- (2) "Agency" means the Agency for Health Care Administration as defined in s. 440.02(3), F.S.
- (3) "Authorization" means the approval given to a health care provider by the insurer or self-insured employer for the provision of medical services to an injured employee.
- (4) "Charge Master" means a comprehensive listing of all the goods and services for which the facility maintains a separate charge, with the facility's charge for each of the goods and services, regardless of payer type. The Charge Master shall be maintained and produced when requested for the purpose of verifying usual charges pursuant to s. 440.13(12)(d), F.S.
- (5) "Division" means the Division of Workers' Compensation of the Department of Financial Services as defined in s. 440.02(14), F.S.
- (6) "Health Care Provider" means a provider as defined in s.440.13 (1), F.S.
- (7) "Hospital" means a health care facility as defined in Chapter 395, F.S.
- (8) "Itemized Statement" means a detailed listing of hospital services and supplies as described in s. 395.301, F.S.
- (9) "Medical Record" means patient records maintained in accordance with form and content required under Chapter 395, F.S.
- (10) "Medical Record Review" means a review of the medical record of the injured employee in order to verify the medical necessity of the services and care as they relate to the itemized statement for a specific bill.

- (11) "Per Diem" means a reimbursement allowance based on a fixed rate per day which is inclusive of all services rather than on a charge by charge basis.
- (12) "Physician" means a physician as defined in s. 440.13(1) (q), F.S.
- (13) "Stop-Loss Method or Stop-Loss Point" means an independent reimbursement methodology used in place of, and not in addition to, per diem reimbursement for an inpatient admission to an acute care hospital or a trauma center when the Total Gross Charges or the Total Gross Charges After Implant Carve-Out exceed \$51,400. The methodology allows reimbursement of 75 percent (75%) of the hospital's charges for only medically necessary services except for surgical implant(s).
- (14) "Surgical Stay" means an admission for which the CMS-defined operative status for the primary procedure reported by the hospital on the hospital billing form is designated as either "operative" or "mixed."
- (15) "Total Gross Charges" means the sum of all charges entered on the hospital billing form during the covered period identified on the hospital bill.
- (16) "Total Gross Charges After Implant Carve-Out" means the Total Gross Charges identified on the hospital bill less the sum of all charges for implants billed pursuant to rule 69L-7.602, F.A.C.
- (17) "Trauma Center" means a hospital approved for certification as a trauma center pursuant to rule 64E-2.06, F.A.C. A list of certified trauma centers is available free of charge on the Department of Health website at <http://www.doh.state.fl.us/demo/Trauma/PDFs/TraumaCenterContacts.pdf>.

APPENDIX B

Rule 69L-7.501, Florida Administrative Code

APPENDIX B: Rule 69L-7.501 Florida Workers' Compensation Reimbursement Manual for Hospitals.

(1) The Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition, is adopted by reference as part of this rule. The Hospital Manual contains the Maximum Reimbursement Allowances (MRAs) determined by the Three Member Panel, pursuant to s. 440.13(12), Florida Statutes, and establishes policy, procedures, principles and standards for implementing statutory provisions regarding reimbursement for medically necessary services and supplies provided to injured workers in a hospital setting. The policy, procedures, principles and standards in the Manual are in addition to the requirements established by the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, rule 69L-7.602, F.A.C. The Reimbursement Manual for Hospitals is available for inspection during normal business hours at the Florida Department of Financial Services, Document Processing Section, 200 East Gaines Street, Tallahassee, Florida 32399-0311, or may be obtained free of charge by print or download from the Department's website at <http://www.fldfs.com/wc>.

(2) The Florida Workers' Compensation Health Care Provider Reimbursement Manual (HCP RM), 2006, incorporated by reference into rule 69L-7.020, F.A.C.; and the Workers' Compensation Medical Services Billing, Filing and Reporting Rule, rule 69L-7.602, F.A.C., are also incorporated by reference into this rule. Both rules and the HCP RM are available for inspection during normal business hours at the Florida Department of Financial Services, Document Processing Section, 200 East Gaines Street, Tallahassee, Florida 32399-0311, or via the Department's web site at <http://www.fldfs.com/wc>.

Specific Authority 440.13 (12), (14), 440.591 FS. Law Implemented 440.13(7), (12), (14), FS. History--New 6-9-87, Amended 6-1-92, 10-27-99, 7-3-01, Formerly 38F-7.501, 4L-7.501, Amended 12-4-03, 1-1-04, 7-4-04, _____.