

**FLORIDA WORKERS' COMPENSATION
REIMBURSEMENT MANUAL FOR
AMBULATORY SURGICAL CENTERS**

2005 Edition

Rule Chapter 69L-7.100, Florida Administrative Code

69L-7.100 Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers (ASCs).

(1) The Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2005 Edition, is adopted by reference as part of this rule. The manual contains reimbursement policies and maximum reimbursement allowances for ambulatory surgical facility services, which are items and services provided in connection with a surgical procedure. The manual contains basic instructions and information for all ambulatory surgical centers and insurers concerning reimbursement of claims for ambulatory surgical facility services.

(2) The Division has incorporated in the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2005 Edition, procedure codes consistent with the Physicians' Current Procedural Terminology (CPT®), 2005 Professional Edition, Copyright 2004, American Medical Association. This publication is adopted by reference as part of this rule. When a procedure is performed which is not listed in the manual, the ambulatory surgical center must use the appropriate code and descriptor contained in the Physicians' Current Procedural Terminology (CPT®), 2005 Professional Edition, Copyright 2004, American Medical Association.

(3) The Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2005 Edition, incorporated above, 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 via the Department's web sit at <http://www.fldfs.com>.

Specific Authority 440.13(14), 440.591 FS. Law Implemented 440.13(7), (12), (14), FS. History-New 8-7-91, Amended 12-31-92, Formerly 38F-7.100, 4L-7.100, Amended _____.

**FLORIDA WORKERS' COMPENSATION
REIMBURSEMENT MANUAL
FOR AMBULATORY SURGICAL CENTERS
2005 EDITION**

In accordance with Section 440.13, Florida Statutes (F.S.), this manual is promulgated to establish the maximum reimbursement allowances which may be paid to authorized freestanding ambulatory surgical centers (ASCs) for items and services furnished in connection with covered procedures provided to Florida's injured employees.

NOTICES AND DISCLAIMERS

The Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2005 Edition, includes descriptive terms, numeric codes and modifiers to be used in reporting ASC services and procedures.

It is expressly understood and agreed that the American Medical Association's rights include, but not limited to, common law and statutory rights of literary property in the CPT and in any update thereto, including all descriptive terms and identifying codes and modifiers for reporting procedures and medical services and/or any other information or materials contained in the CPT and in any update thereto are not assigned or released as a result of the agreement between the American Medical Association and the State of Florida, but are at all times reserved and retained by the American Medical Association.

The five character codes included in the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2005 Edition are obtained from Current Procedural Terminology (CPT[®]), copyright 2004 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 performed by physicians.

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Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2005 Edition. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of CPT. Any use of CPT outside of the Florida Workers' Compensation Ambulatory Surgical Centers Reimbursement Manual, 2005 Edition should refer to the most Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

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SECTION I: ADMINISTRATIVE PURPOSE OF MANUAL

The administrative purpose of the Florida Workers' Compensation Ambulatory Surgical Centers Reimbursement Manual, 2005 Edition is to furnish Florida workers' compensation health care providers with general information, reimbursement policies and maximum reimbursement allowances (MRA) for covered Ambulatory Surgical Centers (ASC) facility services.

SECTION II: ELIGIBILITY

All licensed free-standing Ambulatory Surgical Centers (ASCs) must comply with Chapter 395, Florida Statutes (F.S.).

SECTION III: AUTHORIZATION

- A. All requirements in this manual specifically apply to facility services that are furnished in an independent or freestanding ASC (i.e., not a part of a provider's office or any other facility).
- B. Florida ASC facilities and out-of-state ASC facilities must be authorized by the employee's workers' compensation insurer or a self-insured employer prior to rendering initial and remedial medical services or before referring the injured employee to facilities or other certified health care providers.
- C. Insurers must comply with the statutory requirements in s.440.13, F.S., in responding to authorization requests timely and to ensure that ASC facilities are eligible to receive reimbursement for the treatment being requested.
- D. Neither emergency services and care, defined in s.395.002, F.S., nor a provider referral for emergency treatment resulting from emergency care, require authorization by an insurer. These are the only exceptions to the requirements of prior authorization for medical care and treatment.

SECTION IV: MATERIALS ADOPTED FOR REFERENCE

A. The following publications are adopted by reference with listings of descriptive terms and identifying codes for reporting medical services and procedures provided to injured employees by Ambulatory Surgical Centers:

1. Physicians' Current Procedural Terminology (CPT®), 2005 Professional Edition, Copyright 2004, American Medical Association.

2. Current Dental Terminology (CDT-2005), Copyright 2004, American Dental Association.
 3. HCPCS 2005, Seventeenth Edition, Copyright 2004, Ingenix Publishing Group, for dental D codes, injectable J codes, and the other medical services or supply codes as specified in this manual.
- B. The use of codes and descriptions, modifiers, guidelines, definitions and instructions of the referenced CPT, CDT-2005 and HCPCS shall be used in part for dental codes, injection codes, specific modifiers, and the other medical services or supply codes as specified in this manual.
1. The use of Category III CPT codes for emerging technology, services and procedures must be used when available instead of a Category I CPT unlisted code.
 2. The code descriptors, guidelines, definitions, and instructions of the aforementioned references are not provided in this manual. Any modification to a code descriptor by the workers' compensation program shall be specified and shall take precedence over any descriptor contained in the referenced CPT, CDT-2005 or HCPCS.

SECTION V: MANAGED CARE

An ASC facility may enter a workers' compensation managed care arrangement to provide care and services for an agreed upon contract price. The terms of an agreement may follow the specific requirements of this manual or may contain additional or different requirements.

SECTION VI: MEDICAL RECORDS

ASC facilities shall establish a system for maintaining complete, comprehensive, and accurate medical records according to Chapter 395, F.S.

A. Copying Charges for Medical Records.

1. Injured employee.

Pursuant to s.440.13(4)(b), F.S., when an ASC provides copies of medical records to the injured employee or injured employee's attorney, the facility may charge the injured employee or the injured employee's attorney \$.50 per page for paper medical records copied and the actual direct cost of copying x-rays, microfilm, or other non-paper medical records. No other copy charges or search charges may be charged to the injured employee as part of the services provided to the injured employee by the ASC.

2. Employer/Insurer

Pursuant to s.395.3025, F.S., when an ASC provides copies to the employer or insurer or its attorney upon written request, the ASC facility may charge the following:

- a. \$1.00 per page for medical record;
 - b. \$2 per fiche (microfiche) and other non-paper medical records;
 - c. Actual sales tax and postage for mailing the copies; and
 - d. An additional fee of \$1.00 per year for each year of copies of medical records requested, but no additional search or retrieval fee.
- B. The above charges for copies of medical records apply to each ASC and to any copy services providing copies to the insurer on behalf of the ASC.
- C. No charge shall be reimbursed for copies of the injured employee's medical record provided to the Division or the Agency for Health Care Administration.

SECTION VII: OUT-OF-STATE ASC FACILITY

- A. ASC services provided by an out-of-state facility require authorization from the insurer.
- B. An ASC outside of the state of Florida shall be reimbursed at either:
 1. The amount agreed upon by the ASC and insurer during authorization, or
 2. When no amount is pre-approved, the greater of the reimbursement established under Florida's Workers' Compensation law or rules or the maximum payment amount provided under the workers' compensation statute of the state in which the ASC is located.

SECTION VIII: BILLING

- A. There are two primary elements in the total cost of performing a surgical procedure in an ASC:
 1. The cost of physician's professional services for performing the procedure; and

2. The cost of services furnished by the facility where the procedure is performed; for example, the surgical supplies and equipment and nursing services.
- B. The professional fee is paid to the physician(s); the facility fee is paid to the ASC.
- C. The physician, other health care providers and ASC facilities shall submit their bills in accordance with the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, Rule Chapter 69L-7.602, F.A.C. available at the following website: <http://www.fldfs.com/wc/> (Rules and Forms).

SECTION IX: ASC FACILITY SERVICES

- A. Facility services include all services and procedures furnished in connection with covered surgical procedures performed in an ASC. ASC facility services include the following, but are not limited to:
 1. Nursing and technical personnel services and other related services;
 2. Use of operating and recovery rooms, patient preparation areas, waiting room, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services;
 3. Drugs, biologicals, surgical dressings, splints, casts, surgical supplies and equipment (required for both the patient and ASC personnel, e.g., gowns, masks, drapes, case pack , operating and recovery room equipment), commonly furnished by the ASC in connection with the surgical procedure;
 4. Diagnostic or therapeutic items and services (with respect to diagnostic tests, many ASCs perform simple test just before surgery, primarily such as urinalysis, blood hemoglobin or hematocrit which are generally included in the ASC's facility charges and are considered to be facility services);
 5. Administrative, recordkeeping, and housekeeping items (i.e., administrative functions necessary to run the facility, such as scheduling, cleaning, utilities and rent);
 6. Blood, blood plasma or platelets; (ASC procedures are limited to those not expected to result in extensive loss of blood, but in some cases, blood or blood products are required); and

7. Materials for anesthesia includes the anesthetic itself, and any materials, whether disposable or reusable, necessary for its administration.

SECTION X: NON-ASC FACILITY SERVICES

- A. Non-ASC facility services include a number of items and services reimbursable under Florida Workers' Compensation program that may be furnished in an ASC which are not considered facility services.
- B. The following non-ASC facility services must be billed and reimbursed separately under provisions of the applicable fee schedule.
 1. Physicians' services;
 2. Sale, lease, or rental of durable medical equipment to ASC patients for use in their homes;
 3. Services furnished by an independent laboratory; and
 4. Ambulance Services.

SECTION XI: PATHOLOGY/LABORATORY AND RADIOLOGY/IMAGING SERVICES

A. Pathology/Laboratory Services.

1. Pathology/laboratory services which are performed by the ASC on the day of admission shall be reimbursed separately according to Section XII in this manual when billed under the appropriate 5-digit CPT code.
2. Venipuncture for the collection of a blood specimen shall be considered incidental to the laboratory procedure and shall not be reimbursed separately under procedure code 36415.
3. Pathology/laboratory services provided by an independent clinical laboratory shall be reimbursed directly to the laboratory service provider according to Rule Chapter 69L-7.020, F.A.C. (See Rule Chapter 69L-7.602, F.A.C. for billing instructions.) However, the ASC shall be reimbursed for procedure code 36415 for the collection of a blood specimen that must be conveyed to an independent laboratory.

B. Radiology/Imaging Services.

Radiology/imaging services that are performed by the ASC on the day of the admission are reimbursed separately according

to Section XII of this manual when billed under the appropriate 5-digit CPT procedure code.

C. Preadmission Services.

Preadmission pathology/laboratory or radiology/imaging services required by the physician must be specifically authorized by the insurer to be performed by the ASC and shall be reimbursed according to Section XII of this manual.

SECTION XII: REIMBURSEMENT METHODOLOGY

A. For procedures and Maximum Reimbursement Allowances (MRAs) listed in Section XVI the following reimbursement methodology applies:

1. When an ASC's usual and customary charge is equal to or less than the MRA listed for the procedure, the ASC must be reimbursed 80% of its usual and customary charge or the MRA, whichever is less.
2. If an ASC's usual and customary charge is greater than the MRA listed for the procedure, the ASC must be reimbursed 65% of its usual and customary charge or the MRA, whichever is greater.

B. For procedures which are not listed in Section XVI, reimbursement of a compensable ASC charge shall be 70% of the ASC's usual and customary charge.

C. Surgical implants, orthotic and prosthetic devices or other surgical and medical supplies not incidental to a procedure or service shall be reimbursed separately under procedure code 99070.

1. Reimbursement for these services shall not exceed 20% above the invoice cost, including applicable manufacturer's shipping and handling.
2. The provider must submit an invoice to the insurer that substantiates the cost of the item(s).

SECTION XIII: REIMBURSEMENT FOR MULTIPLE PROCEDURES

A. Reimbursement shall be made for all medically necessary surgical procedures when more than one (1) procedure is performed at a single operative session.

1. Each procedure performed shall be identified by use of the appropriate five-digit CPT code and listed separately.

2. Reimbursement for the primary surgery or most significant procedure is reported first and shall be:
 - a. According to guidelines in Section XII in this manual;
or
 - b. An agreed upon contract price.

- B. Reimbursement shall be made at 50 percent of the ASC's usual and customary charge for additional surgical procedures (listed separately) and identified by appending modifier 51 to the appropriate five-digit CPT code.

- C. Reimbursement for bilateral procedures.
 1. Reimbursement shall be made for bilateral procedures that are performed at the same operative session.
 2. Reimbursement for a bilateral procedure that includes the word "bilateral" in the descriptor shall be:
 - a. According to guidelines in Section XII in this manual; or
 - b. An agreed upon contract price.
 3. Reimbursement for a bilateral procedure that does not include the word "bilateral" in the descriptor shall be made when the procedure is billed twice as follows:
 - a. Reimbursement for the first procedure shall be:
 1. According to guidelines in Section XII in this manual; or
 2. An agreed upon contract price.
 - b. Reimbursement for the second procedure identified by appending modifier 50 to the five-digit procedure code shall be made at 50 percent of the ASC's usual and customary charge.
 4. When a procedure is performed unilaterally and the code descriptor is bilateral, the service shall be identified with modifier 52 and reimbursed according to documentation to explain the reduction in service.

SECTION XIV: Terminated Procedures

A. A claim submitted for reimbursement of a terminated surgery must include an operative report that specifies the following:

1. Reason for termination of surgery;
2. Services actually performed;
3. Supplies actually provided;
4. Services not performed that would have been performed if surgery had not been terminated;
5. Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
6. Time that would have been spent in each of these stages if the surgery had not been terminated; and
7. CPT code(s) for the procedure(s) had the surgery been performed.

B. Terminated procedures shall be reimbursed as follows:

1. No payment shall be allowed for a procedure that is terminated either for medical or non-medical reasons before pre-operative procedures are initiated by staff. For example, payment is disallowed if scheduled surgery is canceled or postponed because patient on intake complains of a cold or flu.
2. Payment shall be 50 percent of the amount allowed for the procedure under Section XII, A or B if a procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating suite but before anesthesia has been induced. For example, 50 percent of rate is paid if the patient develops an allergic reaction to a drug administered by the staff prior to surgery.
3. Payment shall be 100 percent of the amount allowed for the procedure under Section XII, A or B if a medical complication arises which causes the procedure to be terminated after induction of the anesthetic agent. For example, insurer makes full payment if, after anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood

pressure increases suddenly and the surgery is terminated to avoid increasing surgical risk to the patient.

C. Identify a terminated surgical procedure by appending modifier 53 to the 5-digit CPT code. (See Appendix A.)

SECTION XV: REIMBURSEMENT AND UTILIZATION DISPUTES

Contested final disallowance or adjustment of payment by a insurer may be resolved by petitioning the Agency for Health Care Administration pursuant to requirements of s.440.13(7), F.S. and Rule Chapter 59A-31.002, F.A.C.

SECTION XVI: LISTED SCHEDULE OF MAXIMUM REIMBURSEMENT ALLOWANCES

CPT	MRA
20680	\$ 862.40
29870	\$1,320.00
29877	\$1,332.00
29881	\$1,736.00
49505	\$ 900.00
64520	\$ 280.00
64721	\$ 940.00
71020	\$ 64.00
81000	\$ 13.60
85610	\$ 36.80
93000	\$ 66.00

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APPENDIX A

MODIFIERS

APPENDIX A: MODIFIERS

Modifiers change the basic services reported and identifies a procedure or service that has changed due to circumstances. CPT modifiers are 2-digit numeric and/or alphanumeric. Some modifiers impact reimbursement while others are for informational purposes and do not guarantee reimbursement. In some situations it may be necessary for the ASC facility to submit a report with the bill to explain the circumstances in order for an insurer to determine payment.

<u>CPT Modifiers</u>	<u>Description</u>
22	Unusual Procedural Services.
50	Bilateral procedures.
51	Multiple procedures.
52	Reduced Services.
53	Discontinued procedures.

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APPENDIX B
DEFINITIONS

APPENDIX B: DEFINITIONS

1. Agency means the Agency for Health Care Administration as it is defined in s.440.02(3), F.S.
2. Ambulatory Surgical Center means a health care facility as it is defined in s.395.002(3), F.S.
3. Charges mean the dollar amount billed.
4. Division means the Division of Workers' Compensation (DWC) as defined in s.440.02(14), F.S.
5. Emergency Services means emergency services and care as defined in s. 395.002, F.S.
6. Health Care Facility means a facility as defined in s.440.13(1).
7. Health Care Provider means a provider as defined in s.440.13(1).
8. Insurer means an entity as defined in s.440.02(38), F.S.
9. Maximum Reimbursement Allowance (MRA) means the specifically listed maximum dollar amount in the schedule adopted by the three-member panel for reimbursement of medical service(s) rendered to an injured employee by a health care provider.
10. Medically Necessary or Medical Necessity means any medical service or medical supply which meets the definition of the terms according to s. 440.13(1)(1), F.S.
11. Physician means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a chiropractor licensed under chapter 460, a podiatrist licensed under chapter 461, an optometrist licensed under chapter 463, or a dentist licensed under chapter 466, each of whom must be certified by the agency as a health care provider defined in (s.440.13(1)(q), F.S.).

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