38F-7.501 Florida Workers' Compensation Reimbursement Manual for Hospitals.

(1) The Florida Workers' Compensation Reimbursement Manual for Hospitals, 1999 Edition, and replacement pages 4, 9, and 22 are adopted by reference as part of this rule. The manual contains reimbursement policies and per diem rates for hospital services and supplies as well as basic instructions and information for all hospitals and carriers in the preparation and reimbursement of bills for hospital services.
(2) LES Form DWC-90, also known as the UB-92, or HCFA-1450, is hereby incorporated by reference as part of this rule.
(3) The Florida Workers' Compensation Reimbursement Manual for Hospitals, 1999 Edition, and LES Form DWC-90, are available for inspection during normal business hours, at the Division of Workers' Compensation, Bureau of Rehabilitation and Medical Services, 101 Forrest Building, 2728 Centerview Drive, Tallahassee, Florida 32399-0664, or via the Division's home page at http://www2.myflorida.com.les/wc/.

Specific Authority 440.13(4)(b), (6), (11), (12), (14) FS. Law Implemented 440.13(4)(b), (6), (11), (12), (14) FS. History–New 6-9-87, Amended 6-1-92, 10-27-99, 7-3-01.

FLORIDA WORKERS' COMPENSATION

REIMBURSEMENT MANUAL FOR HOSPITALS

1999 EDITION

Rule 38F-7.501, Florida Administrative Code

TABLE OF CONTENTS

Section 1: Managed Care.

Under workers' compensation managed care arrangements, a hospital may enter into various types of written agreements directly or indirectly with carriers to provide and to manage medically necessary remedial treatment, care and attendance to injured employees 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.

In the following text, the word carrier also means the designated authorizing entity in a managed care arrangement contract.

Section 2: Publications Adopted by Reference.

A. The standards and UB-92 form in the following publications are adopted by reference (see Appendix B for ordering information):

1. Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH),with CAMH update 2, dated May 1999. Ordering information can be found in Appendix B to this manual.

2. Length of Stay by Operation, United States, 1999, ISBN: 1-57372-185-0; ISSN 1097-3320. Ordering information can be found in Appendix B to this manual.

3. Length of Stay by Diagnosis, United States, 1999, ISBN: 1-57372-177-8; ISSN: 1099-3312. Ordering information can be found in Appendix B to this manual.

4. UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing

REPLACEMENT PAGE EFFECTIVE 7/3/01

Committee, dated April 1, 2001 (UB-92 Manual). Ordering information can be found in Appendix B to this manual.

B. No reimbursement allowance, basic unit values or relative value guides, conversion factors or scales are included in any part of the above referenced publications.

Section 3: Authorization.

A. Hospital emergency services and care do not require authorization at the time they are rendered. If the emergency medical condition or the care results in an emergency hospital admission of the injured employee, the carrier must be notified within 24 hours by telephone.

B. A hospital shall obtain authorization from the carrier prior to providing non-emergency treatment or the inpatient admission of an employee for a work-related injury.

C. Authorization obtained by the hospital from the carrier shall be recorded by the hospital in the injured employee's medical record or billing or financial record including the date on which authorization was received, and the name and title of the person authorizing medical services.

D. The hospital shall inform the carrier at the time of authorization of any known treatment ordered by the physician for non-compensable conditions which the injured employee is to receive during the course of hospitalization.

Section 4: Precertification and Length of Stay.

A. The carrier shall precertify the number of days for the hospital stay according to national length of stay standards when

the carrier authorizes the hospital to admit the injured employee.

B. When it is evident at time of admission or during the stay that the precertified days will be exceeded, the carrier must be informed and provided the opportunity to approve additional days.

Section 5: Hospital Release of Information Form.

A. The hospital shall obtain a signed release of information form from each patient upon admission which meets the requirements of Chapter 395, Florida Statutes (F.S.).

B. When the patient's condition at the time of the admission prevents compliance with this requirement, the form should be signed by the patient or their guardian, curator, or personal representative as soon as circumstances permit.

C. If the patient refuses to sign the release of information form, the hospital must notify the carrier immediately. When this is not possible, the hospital must notify the carrier by close of business on the next regular business day.

D. The patient's record must include either the signed release of information form or the documentation of refusal to sign the form and the notification to the carrier of the refusal to sign the form.

E. Specific records cannot be disclosed without consent of the person to whom they pertain. These records include:

1. Mental health records (s. 394.4615, F.S.);

2. Records of substance abuse impaired persons (s.

397.501, F.S.);

3. The identity and test results of persons upon whom a test for human immunodeficiency virus has been made (s. 381.004 (3), F.S.).

Section 6: Medical Records.

A. The hospital shall maintain medical records according to Chapter 395, F.S., Chapter 400, F.S., and standards of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), if so accredited.

B. The hospital shall maintain documentation in the injured employee's medical record of the injured employee's condition and all medical services ordered and provided to the injured employee during the injured employee's length of stay in the hospital. The documentation shall substantiate the medical necessity of the services ordered and provided during the stay in the hospital.

C. When it is necessary to substantiate the medical necessity for a hospital service or stay, supporting documentation must be provided by the prescribing physician. Such documentation includes:

(1) Objective findings which substantiate the need for the medical care and treatment.

(2) The estimated period of time or the estimated number of days required for hospitalization.

(3) The anticipated benefits to the patient.

(4) The reasons for continuing treatment in the hospital.

(5) Any other information which can substantiate the medical necessity for the hospital service(s) or stay.

Section 7: Copy Charges for Medical Records.

A. If a hospital provides copies of medical records to the injured employee or injured employee's attorney, the hospital may charge the injured employee or the injured employee's attorney $.50 per page of 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 hospital.

B. If a hospital provides copies to the carrier upon the carrier's written request under section 395.3025, F.S., the hospital may charge the following:

(1) $1.00 per page of paper medical record.

(2) $2.00 per fiche (microfiche) and other non-paper medical records.

(3) Actual sales tax and postage for mailing the copies to the carrier, and

(4) An additional fee of $1.00 per year for each year of copies of medical records requested, but no additional search or retrieval fee.

C. The above charges for copies of medical records apply to each hospital and to any copy services providing copies to the carrier on behalf of the hospital.

D. No copy charges shall be allowed for copies of the injured employee's medical record provided to the Division.

Section 8: Out of State Hospital Services.

A. Hospital services, provided by an out-of-state hospital, require authorization from the carrier.

B. All requirements of this manual apply to hospital services supplied to an injured employee outside of the state of Florida, except for reimbursement amounts, which are addressed in C. below.

C. A hospital outside of the state of Florida shall be reimbursed at either:

(1) The amount agreed upon by the facility and the carrier during authorization, or

(2) When no amount was pre-approved, the greater of the reimbursement established under Florida's Workers' Compensation law or rules (see Section 11) or the maximum payment amount provided under the workers' compensation statute of the state in which the hospital is located.

Section 9: Federal Facilities.

A. Treatment provided in federal facilities requires authorization from the carrier.

B. All requirements of this manual apply to hospital services supplied to an injured employee in a federal hospital except that federal facilities:

(1) Bill on their own billing form instead of the LES Form DWC-90 (UB-92); and

(2) Are not subject to the reimbursement limitations of this rule.

REPLACEMENT PAGE EFFECTIVE 7/3/01

Section 10: Claim Form Completion and Reporting Requirements.

A. A hospital shall use the LES Form DWC-90, also known as UB-92, in billing for medical services it provides to an injured employee.

B. The LES Form DWC-90 must be completed according to the billing guidelines contained in the UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, dated April 1, 2001 (UB-92 Manual). Ordering information can be found in Appendix B to this manual.

C. A fraud statement shall be on the back of the LES Form DWC-90.

D. Any attachments to the LES Form DWC-90 other than an itemized statement shall be labeled in the upper right corner of the page of the attachment with the injured employee's name, social security number or alien registration number, and date of accident.

E. A hospital shall submit a legible and complete LES Form DWC-90 to the carrier within the following parameters:

(1) Emergency services - within 15 calendar days of discharge from the emergency department.

(2) Outpatient treatment:

(a) Within 15 Calendar days of first service or treatment.

(b) At least every 30 calendar days thereafter for follow-up treatment.

(3) Inpatient treatment less than 30 calendar days: The "Admit through Discharge" bill must be submitted within 30 calendar days of final treatment or discharge. This bill should represent all services delivered.

(4) For extended stays over 30 calendar days:

(a) Interim-First Claim - within 45 calendar days of admission.

(b) Interim-Continuing Claim - every 30 calendar days thereafter until the patient is discharged.

(c) Interim-Last Claim - within 30 calendar days after discharge.

F. Itemized Statement.

(1) All hospitals including psychiatric hospitals and rehabilitative hospitals shall submit to the carrier an itemized statement with the LES Form DWC-90 unless the specific itemization (not global revenue center charges) is listed on the LES Form DWC-90 itself.

(2) All itemized statements shall contain the following information:

(a) Injured employee's name.

(b) Injured employee's social security number or alien registration number.

(c) Date of accident.

(d) Date(s) of service.

(e) Total number of units for each service listed.

(f) Total dollar charge for all units billed for each service listed.

(3) For each item listed on the itemized statement,

the information in (2)(e) and (2)(f) above shall be provided.

G. The carrier shall enter the carrier code number in the upper right corner of the LES Form DWC-90 and on each document attached to the LES Form DWC-90.

H. The carrier shall accept and pay, adjust or disallow, a legible and complete hospital bill within 45 calendar days of receipt. An incomplete or illegible LES Form DWC-90 should be returned by the carrier to a hospital within 14 days for proper completion before reimbursement is made.

I. The carrier shall enter on the LES Form DWC-90, in form locator 84a, the actual amount reimbursed to the hospital.

J. The carrier shall submit the completed LES Form DWC-90 to the Division within 30 calendar days after the reimbursement has been mailed to the hospital. The carrier may submit LES Form DWC-90 data to the Division by electronic media (see Section 13).

Section 11: Reimbursement.

A. Acute care hospitals and trauma centers shall be reimbursed on a per diem basis as follows:

(1) Inpatient services provided by an acute care hospital:

(a) Surgical stay: $3,213.73

(b) Non-surgical stay: $1,906.89

(2) Inpatient services provided by a trauma center:

(a) Surgical stay: $3,214.66

(b) Non-surgical stay: $1,931.96

(3) When charges for inpatient services at either an acute care hospital or a trauma center exceed $50,000.00, a stop-

loss point for that case having been reached, the hospital shall be reimbursed at 75 percent of its usual and customary charges for all charges incurred on that case by that hospital, instead of the established per diem.

B. Inpatient services provided at a rehabilitative hospital or a psychiatric hospital shall be reimbursed at 75 percent of its usual and customary charges.

C. All medically necessary outpatient hospital services shall be reimbursed at 75 percent of its usual and customary charges.

D. A carrier may not disallow any portion of the length of stay for an authorized inpatient admission except when documentation does not support medical necessity or when the length of stay exceeds:

(1) Precertified days.

(2) Median length of stay (50^{th} percentile) of national length of stay standards.

E. When non-compensable services are provided during a stay for compensable services and the length of stay for the non-compensable condition exceeds that required for the compensable condition, all charges for the additional length of stay are the patient's responsibility and must not be reimbursed under workers' compensation.

F. When necessary, the carrier may perform utilization on-site audits to justify the length of stay and the hospital services to determine the medical necessity of the charges billed. The carrier may also review the hospital's charge master to verify that the charges for services are the actual charges

listed on the itemized statement.

G. If it is necessary to conduct a utilization on-site audit, the carrier must inform the hospital in writing within 30 calendar days from the date of receipt of the completed LES Form DWC-90.

H. Within 30 calendar days of a written request for an audit, a hospital shall schedule the audit without any conditions of prepayment or audit administrative charges.

I. Payment to a hospital is based on proper claims submission by the hospital for medically necessary services and is not contingent upon completion of an audit.

J. A carrier, upon receipt of a properly completed hospital claim form, must pay, adjust or disallow the claim within 45 days. Payment for a specific service, however, may be disallowed by the carrier if the medical necessity of that service is questionable.

K. Reimbursement to a hospital must not be delayed because the carrier has not received or reviewed copies of the medical records.

L. When it is determined that an underpayment or overpayment has been made, the owing party shall reimburse the other party within 30 calendar days.

M. Failure of either party to identify overcharges or undercharges during the periods of time listed above in G. and H. constitutes a waiver of either one's right to reimbursement at a later date.

N. A reimbursement dispute may be appealed to the Division in accordance with s. 440.13(7), F.S., and s. 440.134(6), F.S.

Section 12. Explanation of Bill Review (EOBR).

A. When adjusting or disallowing a charge on the LES Form DWC-90, the carrier shall send an EOBR to the hospital as well as retain a copy on file. The copy of the EOBR may be retained electronically.

B. Acceptable EOBRs are legible forms which contain the patient control number, the injured employee's social security number or alien registration number, the date of accident, the date(s) of service, the EOBR codes, and explanation(s) of why the service(s) were not paid as billed. If the reimbursement is mailed separately from the EOBR, the reimbursement check or stub must contain the patient control number, social security number or alien registration number, date of accident and date of service.

C. When the check and EOBR are mailed separately, the time frame for a reimbursement dispute is the latest date of receipt of either check or EOBR.

D. A carrier shall use the EOBR codes contained in this section to explain why the charges were not paid as billed.

E. A carrier may develop additional EOBR codes and descriptors, if necessary, to explain the reimbursement of a bill for medical services and must furnish to the hospital a written explanation of each additional EOBR code.

F. EOBR Codes:

01. Reimbursement is based on contracted amount for service billed.

02. Charge(s) is included in per diem reimbursement.

03. Reimbursement is based on charges exceeding the stop-loss point.

04. No documentation to support the services billed.

05. Incorrect billing form.

06. Billing illegible.

07. Billing incomplete. (Carrier must specify.)

08. Itemized statement not submitted with LES Form DWC-90.

09. Hospitalization not authorized by the carrier or designated party.

10. Charge for inpatient hospitalization exceeds precertified length of stay and the hospital medical record does not document that further hospitalization was medically necessary based on the severity of the illness or the intensity of the services.

11. Charges for services provided for a noncompensable condition(s) determined by carrier at time of authorization.

12. Professional charges are not reimbursable on the LES Form DWC-90.

Section 13: Electronic Submission of Data.

A. Hospitals may submit required data via electronic media directly to the carrier providing the carrier agrees to accept data electronically.

B. A carrier wishing to use an alternative electronic reporting method for submitting required data to the Division, or to change from any existing approved alternative electronic reporting method, shall obtain prior approval from the Bureau of

Rehabilitation and Medical Services.

C. If the carrier has been approved to submit an LES Form DWC-90 to the Division via electronic media, and is retaining the data on electronic media, the Division does not require the carrier to retain paper copies of those forms.

Appendix A: Definitions.

(1) **Admission.** 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) **Authorization.** Approval given to a hospital or federal facility by the carrier or designated party for the provision of medical services to an injured employee who has had a compensable injury.

(3) **Billing.** The completion and submission of the required Division claim form(s) to the carrier in order to receive reimbursement for health care services provided to an injured employee.

(4) **Carrier.** The insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual insurer.

(5) **Charge (Fee).** The dollar amount billed by hospitals for providing hospital services.

(6) **Charge Master (Price List Master).** A comprehensive list maintained by each hospital which delineates a hospital's usual charge for a specific hospital service.

(7) **Division.** The Division of Workers' Compensation of the Department of Labor and Employment Security (s. 440.02(12), F.S.).

(8) **DWC-90.** The current hospital billing form, the UB-92, pursuant to s. 627.647, F.S.

(9) **Emergency Hospital Admission.** The unscheduled admission of a patient for inpatient hospital care for the immediate medical or surgical treatment of an acute

on-the-job injury to prevent loss of life, further irreparable physical damage, or serious impairment of body function which may result from the acute condition.

(10) **Emergency Medical Condition.**

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a treat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes (s. 395.002 (9), F.S.).

(11) **Emergency Services and Care.** Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility (s. 440.13(1)(g) and 395.002(9), F.S.).

(12) **Explanation of Bill Review (EOBR).** A written explanation by the carrier to the hospital that identifies procedures or services which have not been reimbursed as billed, the amount reimbursed, and the reason for each disallowed or adjusted reimbursement.

(13) **Fraud Statement.** Pursuant to s. 440.105(7), F.S., a fraud statement is a statement that in substance states: "Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree."

(14) **Itemized Statement.** A detailed listing of the specific services and supplies, along with the quantity and charges for each, incurred during the hospital stay. Each statement shall meet the criteria provided in s. 395.301, F.S.

(15) **Length of Stay Standards.** A series of tables organized according to HCIA's detailed patient and clinical data and broken down by diagnosis and operation.

(16) **Medical Record.** Information maintained in accordance with Chapter 395, F.S., or Chapter 440, F.S., that identifies the injured employee, provides the diagnosis, justifies the treatment and documents the course and outcome of the treatment rendered.

(17) **Medical Services.** Remedial treatment, care and attendance provided Workers' Compensation injured employees by health care providers pursuant to s. 440.13, and 440.134, F.S.

(18) **Medically Necessary**. Any medical service or medical supply which is used to identify or treat an illness or injury

is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature, except in those instances in which prior approval of the Agency for Health Care Administration has been obtained. The Agency of Health Care Administration shall adopt rules providing for such approval on a case-by-case basis when the service or supply is shown to have significant benefits to the recovery and well-being of the patient (s.440.13 (1) (m), F.S.).

(19) **Per Diem.** A reimbursement allowance based on an all inclusive, established daily rate.

(20) **Physician.** 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 division as a health care provider (s. 440.13 (1) (r), F.S.).

(21) **Stop-Loss Point.** The threshold after which the inpatient stay in an acute care hospital or a trauma center is reimbursed at 75 percent of the hospital's usual and customary charges for all medically necessary services incurred during the patient's entire stay in the hospital instead of the per diem rate.

(22) **Utilization On-Site Audit.** An audit conducted at the

(22) **Utilization On-Site Audit.** An audit conducted at the hospital which compares the charges listed on an itemized statement accompanying the DWC-90 (UB-92) with the charges listed on the hospital's charge master. It includes verifying that services were ordered and provided to the patient by reviewing the documentation in the patient's medical record.

REPLACEMENT PAGE EFFECTIVE 7/3/01

Appendix B: Resource Documents

1. Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH), with CAMH update 2, dated May 1999. Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181. Telephone: (630) 792-5800.
2. Length of Stay by Operation, United States, 1999, ISBN: 1-57372-185-0; ISSN: 1097-3320. HCIA Inc., 300 East Lombard Street, Baltimore, Maryland 21202. Telephone: (800) 568-3282.
3. Length of Stay by Diagnosis, United States, 1999, ISBN: 1-57372-177-8; ISSN: 1099-3312. HCIA Inc., 300 East Lombard Street, Baltimore, Maryland 21202. Telephone: (800) 568-3282.
4. UB-92, National Uniform Billing Data Element Specifications as Adopted by the Florida State Uniform Billing Committee, dated April 1, 2001 (UB-92 Manual). Florida Hospital Association, Post Office Box 531107, Orlando, Florida 32853-1107. Telephone: (407) 841-6230.