DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF WORKERS' COMPENSATION

FORM DFS-F5-DWC-90-B (UB-04) COMPLETION INSTRUCTIONS FOR AMBULATORY SURGICAL CENTERS (For dates of services on and after 07/08/2010)				
AMBULATORY SURGICAL CENTER (ASC) PROVIDERS SHALL COMPLETE THE DFS-F5-DWC-90 (UB-04) ACCORDING TO THE NATIONAL UNIFORM BILLING COMMITTEE OFFICIAL UB-04 DATA SPECIFICATIONS MANUAL (UB-04 MANUAL), AS INCORPORATED BY REFERENCE IN RULE 69L-8.072, F.A.C., UNLESS MODIFIED BY THESE INSTRUCTIONS.				
FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
1	PROVIDER NAME, ADDRESS AND TELEPHONE NUMBER	REQUIRED	Enter the provider's name and a valid telephone number and the physical address (including zip code) of the place where services were rendered.	NO
2	PAY-TO NAME AND ADDRESS	REQUIRED	Enter the name and address where the provider listed in form locator 1 expects payment to be remitted.	NO
3a	PATIENT CONTROL NUMBER	CONDITIONAL	Assigned by ASC.	NO
3b	MEDICAL/HEALTH RECORD NUMBER	CONDITIONAL	Assigned by ASC.	NO
4	TYPE OF BILL	REQUIRED	Pursuant to the UB-04 Manual. Only bill type "83x" is accepted for ASCs.	YES

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5	FEDERAL TAX NUMBER	REQUIRED	Enter the Federal Tax Identification Number of the ASC where the service is provided. Also known as the Tax ID number (TIN).	YES
6	STATEMENT COVERS PERIOD	REQUIRED	Enter dates of service in MMDDYY format.	NO
7	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
8a	PATIENT NAME/IDENTIFIER	REQUIRED	Enter the patient's name Last Name, First Name and Middle initial if applicable.	NO
8b	PATIENT NAME/IDENTIFIER	REQUIRED	Enter the patient's Social Security Number or Division Assigned Number	YES
9a-e	PATIENT ADDRESS	REQUIRED	Enter the patient's mailing address including street address, apartment number or other identifiers, city, state and zip code.	NO
10	PATIENT BIRTHDATE	REQUIRED	Enter the patient's date of birth in MMDDYYYY format.	NO

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11	PATIENT SEX	REQUIRED	Enter sex of the patient: “M” for Male “F” for Female “U” for Unknown	NO
12	ADMISSION DATE	NOT REQUIRED		NO
13	ADMISSION HOUR	NOT REQUIRED		NO
14	ADMISSION TYPE	NOT REQUIRED		NO
15	ADMISSION SOURCE	NOT REQUIRED		NO
16	DISCHARGE HOUR	NOT REQUIRED		NO
17	PATIENT DISCHARGE STATUS	NOT REQUIRED		NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
18	CONDITION CODES	REQUIRED	Enter code “02” in Form Locator 18.	NO
19-28	CONDITION CODES	CONDITIONAL	Use of other applicable codes from the UB-04 Manual is optional (if other codes are listed, list them in alphanumeric order in Form locators 19 through 28).	NO
29	ACCIDENT STATE	NOT REQUIRED		NO
30	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
31	OCCURRENCE CODES AND DATES	REQUIRED	Enter code “04” and enter the date of the accident/illness/injury as MMDDYY.	NO
32-34	OCCURRENCE CODES AND DATES	NOT REQUIRED		NO
35-36	OCCURRENCE SPAN CODES AND DATES	NOT REQUIRED		NO

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37	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
38	RESPONSIBLE PARTY NAME AND ADDRESS	REQUIRED	Enter the name and mailing address of the workers' compensation insurer identified in form locator 50. Must enter name, address and zip code.	NO
39-41	VALUE CODES AND AMOUNTS	NOT REQUIRED		NO
42	REVENUE CODE	REQUIRED	Pursuant to the UB-04 Manual.	YES
43	REVENUE DESCRIPTION	REQUIRED	Enter a brief description that corresponds to the Revenue Code in column 42.	NO
44	HCPCS/ RATES/HIPPS RATE CODES	REQUIRED	Pursuant to the UB-04 Manual and Rule 69L-7.100, F.A.C., CPT or workers' compensation unique code(s) and modifier(s) are required for all applicable Revenue Codes.	NO
45	SERVICE DATE	REQUIRED	Service Date: Enter the date services are provided. (Applies to Lines 1-22 only.) Use MMDDYY format. Creation Date: Enter the date in MMDDYY format that the bill is created on Line 23. This date shall be reported on all pages of the bill.	YES

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
46	SERVICE UNITS	REQUIRED	Pursuant to the UB-04 Manual.	NO
47	TOTAL CHARGES	REQUIRED	Total of all billed charges. Total at bottom of field number 47 is a summation of all of the individual charges for each line item.	NO
48	NON-COVERED CHARGES	NOT REQUIRED		NO
49	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
50	PAYER NAME	NOT REQUIRED		NO
51	HEALTH PLAN IDENTIFICATION NUMBER	NOT REQUIRED		NO
52	RELEASE OF INFORMATION CERTIFICATION INDICATOR	NOT REQUIRED		NO

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53	ASSIGNMENT OF BENEFITS CERTIFICATION NUMBER	NOT REQUIRED		NO
54	PRIOR PAYMENTS-PAYER	NOT REQUIRED		NO
55	ESTIMATED AMOUNT DUE-PAYER	NOT REQUIRED		NO
56	NATIONAL PROVIDER IDENTIFIER (NPI)	REQUIRED	Enter the NPI Number of the ASC where services were provided.	NO
57	OTHER PROVIDER IDENTIFIER	REQUIRED	Enter the alpha characters 'ASC' followed by the facility license number issued by the Florida Agency for Health Care Administration, i.e. ASC####. Out-of-State providers enter the WC unique license #ZZ99999999999.	NO
58	INSURED'S NAME	NOT REQUIRED		NO
59	PATIENT'S RELATIONSHIP TO INSURED	NOT REQUIRED		NO

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60	INSURED'S UNIQUE IDENTIFIER	NOT REQUIRED		NO
61	(INSURED) GROUP NAME	NOT REQUIRED		NO
62	INSURANCE GROUP NUMBER	NOT REQUIRED		NO
63	TREATMENT AUTHORIZATION CODES	REQUIRED	Enter authorization code, authorization or individual's name providing prior authorization for services requested.	NO
64	DOCUMENT CONTROL NUMBER (DCN)	NOT REQUIRED		NO
65	EMPLOYER NAME (OF THE INSURED)	CONDITIONAL	Pursuant to the UB-04 manual, as applicable to ASCs.	NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
66	DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD REVISION INDICATOR)	REQUIRED	Enter the applicable ICD indicator to identify which version of ICD codes are being reported: 9=ICD-9 0=ICD-10 NOTE: ICD-9 shall be used for dates of service prior to the 10/01/2015 federal implementation date for the use of the ICD-10. ICD-10 shall be used for dates of service on or after the 10/01/2015 federal implementation date. (ICD-9 AND ICD-10 CODES CANNOT BE USED TOGETHER.)	YES
67	PRINCIPAL DIAGNOSIS CODE	REQUIRED	Enter the principal ICD diagnosis code describing the condition, present at the time of admission or after the admission that is responsible for the admission of the patient for care. NOTE: ICD-9 shall be used for dates of service prior to the 10/01/2015 federal implementation date for the use of the ICD-10. ICD-10 shall be used for dates of service on or after the 10/01/2015 federal implementation date. (ICD-9 AND ICD-10 CODES CANNOT BE USED TOGETHER.)	NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
67 A-Q	OTHER DIAGNOSIS CODES	CONDITIONAL	Pursuant to the UB-04 Manual. Enter the ICD diagnosis code describing the condition that co-exists at the time of admission that may affect the patient's current care. NOTE: ICD-9 shall be used for dates of service prior to the 10/01/2015 federal implementation date for the use of the ICD-10. ICD-10 shall be used for dates of service on or after the 10/01/2015 federal implementation date. (ICD-9 AND ICD-10 CODES CANNOT BE USED TOGETHER.)	NO
68	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
69	ADMITTING DIAGNOSIS CODE	NOT REQUIRED		NO
70a-c	PATIENT'S REASON DX	NOT REQUIRED		NO
71	PROSPECTIVE PAYMENT SYSTEM (PPS) CODE	NOT REQUIRED		NO

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FIELD NO.	**FIELD NAME**	**FIELD STATUS**	**COMMENTS**	**SUBJECT TO SEND BACK POLICY 69L-7.740(11)(g)**
72a-c	EXTERNAL CAUSE OF INJURY (ECI) CODE	NOT REQUIRED		NO
73	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		NO
74	PRINCIPAL PROCEDURE CODE AND DATE	NOT REQUIRED		NO
74a-e	OTHER PROCEDURE CODES AND DATES	NOT REQUIRED		NO
75	RESERVED (FOR USE BY THE NUBC)	NOT REQUIRED		N0
76	ATTENDING PROVIDER NAME AND IDENTIFIERS	REQUIRED	Enter the attending provider's name (Last, First) after the labeled 'Attending'. Enter the provider's Florida Department of Health license number after the block labeled 'Qualifier'. Out-of -State providers enter the WC unique license number "ZZ99999999999".	NO
77	OPERATING PHYSICIAN NAME AND IDENTIFIERS	REQUIRED	Enter the operating provider's name (Last, First) after the labeled 'Operating'. Enter the provider's Florida Department of Health license number after the block labeled 'Qualifier'. Out-of- State providers enter the WC unique license number "ZZ99999999999".	NO

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78-79	OTHER PROVIDER NAMES AND IDENTIFIERS	NOT REQUIRED		NO
80	REMARKS FIELD	CONDITIONAL	When billing for implant services reported under REV Code 278, the certification amount requested for reimbursement must be determined in accordance with the percentages defined in Rule 69L-7.100, F.A.C. Each component of Implants, Disposables and Shipping must be listed separately in Form Locator 80 by using the required modifiers: (IM, DI, SH) with their associated requested amount. Enter in dollar and cent format for each category.	NO
81a-d	CODE-CODE FIELD	NOT REQUIRED		NO