JIMMY PATRONIS FLORIDA'S CHIEF FINANCIAL OFFICER

FLORIDA WORKERS' COMPENSATION

Health Care Provider

Reimbursement Manual

2024 Edition

Rule 69L-7.020, F.A.C.

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Prepared by:

Division of Workers' Compensation
Department of Financial Services

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Reimbursement Manual Contents

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Introduction & Overview

Background

There are three (3) different Workers' Compensation Reimbursement Manuals:

- Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, Rule 69L-7.100, Florida Administrative Code (F.A.C.);
- Florida Workers' Compensation Health Care Provider Reimbursement Manual, Rule 69L-7.020, F.A.C.; and
- Florida Workers' Compensation Reimbursement Manual for Hospitals, Rule 69L-7.501, F.A.C.

Legal Authority

The following statutes and rule chapter govern workers' compensation billing, filing, and reporting in Florida:

- Chapter 440, Florida Statutes (F.S.)
- Rule Chapter 69L-7, F.A.C.
- The specific Florida Statutes and Florida Administrative Code for each service are cited for reference in each specific manual, where appropriate.

How to Obtain or Purchase Hard Copy Manuals

This Manual can be obtained free of charge on Division of Workers' Compensation (DWC) website at https://www.myfloridacfo.com/Division/WC, under "Reimbursement Manuals," or may be purchased in hard copy from the Department of Financial Services, Document Processing Section, at 200 East Gaines Street, Tallahassee, Florida 32399-0311.

Workers' Compensation Health Care Provider Fee Schedule

The Maximum Reimbursement Allowances (MRAs) for health care providers are no longer contained in the Florida Workers' Compensation Health Care Provider Reimbursement Manual (Manual). The MRAs are established by statute and can be found on the DWC website at https://www.myfloridacfo.com/Division/WC.

Program Requirements

Purpose

The Manual contains instructions for reimbursing health care providers.

Unless otherwise specified in this Manual, the terms "insurer" and "carrier" are used interchangeably and have the same meanings as defined in section 440.02, F.S., and may also refer to a service company, Third-Party Administrator (TPA), or any other entity acting on behalf of a carrier for the purposes of administering workers' compensation benefits for its insured(s).

Fraud Statement

Any health care provider that makes claims for services provided to the claims-handling entity on a recurring basis may make one personally signed attestation to the claims-handling entity as required by section 440.105(7), F.S., which must satisfy the requirement for all claims submitted to the claims-handling entity for the calendar year in which the signed attestation is submitted.

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or worker, insurance company, or self-insured program, files a statement of medical bill containing any false or misleading information commits insurance fraud, punishable as provided in section 817.234, F.S.

Carrier Responsibilities

A carrier is responsible for meeting its obligations under section 440.13(3), F.S., and Rule 69L-7.740, F.A.C., along with the requirements found in this Manual and is accountable regardless of any business arrangements with any service company, TPA, submitter, or any entity acting on behalf of the carrier under which claims are paid, adjusted, disallowed, or denied to health care providers.

Prior Authorization of Services

Both Florida health care providers and out-of-state providers must have authorization by the Workers' Compensation carrier prior to:

- Rendering initial care, remedial medical services, and pharmacy services; or
- Making a referral for the injured worker to facilities or other health care providers.

At the time of authorization for medical service(s), a carrier must inform out-of-state health care providers of the specific reporting, billing, and submission requirements of this Manual and provide the specific address for submitting a medical bill.

Exceptions to prior authorization are:

- Federal facilities;
- Emergency services and care, defined in section 395.002, F.S.; or
- A health care provider referral for emergency treatment resulting from emergency services.

Documenting Prior Authorization

The health care provider must record the authorization documentation in the injured worker's medical record or in the health care provider's billing records or financial record(s).

Such authorization documentation should include:

- The date(s) on which the authorization was requested and received (whether verbally or in writing);
- The name of the carrier or its designated entity; and
- The name of the person authorizing the health care provider services.

The health care provider's failure to produce authorization documentation may result in the health care provider being ineligible for payment pursuant to section 440.13(3) and (7), F.S.

Notification of Emergency Treatment

A health care provider who renders emergency care must notify the carrier by the close of the third business day after it has rendered such care.

If the emergency care results in admission to a health care facility, the health care provider must notify the carrier by telephone within 24 hours after initial treatment.

Carrier Use of Codes, Descriptors, and References

Carriers must use the codes and descriptions, modifiers, guidelines, definitions, and instructions of the incorporated reference material as specified in Rule 69L-7.020, F.A.C., prior to making reimbursement decisions.

In addition, where not inconsistent with instructions in this Manual, carriers may utilize the National Correct Coding Initiative (NCCI) edits in effect on the date(s) of service as part of the bill review process.

Medical Records

Medical Records

When requested by the carrier it is the responsibility of all health care providers to furnish medical records, reports, and information relevant to the particular injury or illness for which compensation is sought pursuant to paragraph 440.13(4)(c), F.S.

Failure of the health care provider to submit documentation requested by the carrier may result in the health care provider being ineligible for payment pursuant to section 440.13(3) and (4), F.S.

Copying Charges for Medical Records

Any copying charges for medical records shall be paid pursuant to paragraph 440.13(4)(b), F.S.

Division or Judge of Compensation Claims Requests

A health care provider, upon request, must provide medical records and reports to the Division or Judge of Compensation Claims without charge.

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General Reimbursement Information

Billing the Injured Worker

Health care providers must not bill the injured worker for services rendered for a compensable work-related injury except when it is to collect a co-payment fee or when apportioning out the percentage of care attributable to a pre-existing condition.

Co-Payments

A health care provider is entitled to collect a co-payment of $10.00 per visit when providing medical services and care to an injured worker who has reached overall maximum medical improvement (MMI) for the work-related injury.

Co-payment(s):

- May only be collected for evaluation and management visits after the injured worker has received an assignment of MMI;
- Must not apply to emergency care or services provided to the injured worker;
- Must not apply to laboratory, radiology, or diagnostic services; and
- Are not in addition to the MRA or fee agreement.

The reimbursement amount otherwise payable by the carrier must be reduced by the amount of the co-payment.

Federal Facilities

Federal facilities are exempt from the reimbursement provisions and allowances in the fee schedule. A carrier must reimburse a federal facility its usual charge.

Florida Health Care Providers

Reimbursement must be made to a Florida health care provider after applying the appropriate reimbursement policies in place at the time the service was provided.

A carrier must reimburse a health care provider either:

- According to an agreed upon contract price; or
- The MRA.

Out-of-State Providers

Prior to the delivery of medical services, a carrier and a health care provider must agree upon the amounts of reimbursement for the services at the time of authorization or, if no agreement is made prior to the service being rendered, the carrier must reimburse:

- According to an agreed upon contract price; or
- The MRA in the fee schedule for locality 03.

Reimbursement for Procedure Codes Not Listed in the Fee Schedule

In the event that a new CPT® or HCPCS Level II® code is created in the CPT® or HCPCS Level II® manuals released subsequent to the applicable manual incorporated by reference in rule, the health care provider may bill the newly created CPT® code or HCPCS Level II® code that was in place at the time the service was provided.

When the health care provider bills a valid procedure code found in the CPT® or the HCPCS Level II® manual that corresponds to the date of service, and the procedure code is not listed in the fee schedule, reimbursement is determined by:

- Comparing the billed procedure code with a clinically similar procedure code found in the fee schedule;
- The health care provider's documentation and medical bills; or
- The National Physician Fee Schedule Relative Value File copyrighted by the American Medical Association.

At a minimum, reimbursement must be the Florida Workers' Compensation MRA for a clinically similar procedure code that is listed in the fee schedule or an agreed upon contract price.

Carriers must have an established methodology for determining reimbursement for procedure codes that are not listed in the fee schedule and the methodology must be available upon request by the Division.

Reimbursement for Failed Appointments

Reimbursement is not made for an injured worker's failed appointment.

Note: This exclusion does not apply to Independent Medical Examinations pursuant to section 440.13(5)(d), F.S.

Exceptions to Service Limitations

When a health care provider deems it medically necessary in the treatment of an injured worker's injury or illness to furnish medical services that exceed the number of services in the reimbursement policies in this Manual, a health care provider must:

- Submit documentation to the carrier substantiating the medical necessity for the request; and
- Receive specific written authorization from the carrier to render the requested additional services before they are provided.

Services Unrelated to the Compensable Injury

Carriers must not reimburse a health care provider for services unrelated to the treatment or care of a compensable injury except when the treatment is required to stabilize or maintain the injured worker's medical status in order to treat the patient's compensable injury or condition.

Classification of an Injured Worker's Treatment/Status

General Policies

Health care providers are to utilize the Workers' Compensation specific patient classification levels when submitting the required treatment status on the DFS-F5-DWC-25 (DWC-25) form to the carrier.

Classification System

The following best describes the patient classification levels:

- Criteria based;
- Comprised of descriptive categories to provide a means to promote decision-making, accountability, and responsible medical bill handling practices; and
- Neither hierarchical nor severity indicators.

Purpose of Proper Patient Classification

Proper classification of the patient is intended to:

- Convey to carriers the complexity of services that may be required for optimal clinical management;
- Distinguish the overall critical differences among cases that influence the intensity, scope, and cost of services provided;
- Facilitate recognition of three varying clinical configurations that affect the medical treatment plan and treatment progress or other available benefits for an injured worker;
- Assist the carrier in decisions related to authorization of recommended treatment plans or treatment plan revisions;
- Ensure that on-going treatment plans and authorized reimbursable services are consistent with the high intensity, short duration treatment approach which focuses on specific clinical dysfunction before authorization is made to a health care provider; and
- Enhance communication between the health care provider and the carrier to facilitate the authorization process for the provision of medically necessary care.

Patient Classification Levels

Level I: Key issue – specific, well defined medical condition, with clear correlation between objective relevant findings and patient's subjective complaints. Treatment correlates to specific findings.

Level II: Key issue – regional or generalized de-conditioning (i.e., deficits in strength, flexibility, endurance, and motor control). Treatment includes physical reconditioning or functional restoration.

Level III: Key issue – poor correlation between patient's complaints and objective, relevant physical findings, both somatic and non-somatic clinical factors. Treatment includes interdisciplinary management and rehabilitation.

Anesthesia Services

Reimbursable Providers

Anesthesia services are reimbursed to anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesia assistants (AAs) practicing within the scope of state licensure. A surgeon may also be reimbursed for anesthesia services performed during surgery.

Anesthesia Minutes

Anesthesia time begins when the provider starts to prepare the injured worker for anesthesia care in the operating room or in an equivalent area and stops when the provider is no longer in personal attendance, which is when the injured worker may be safely placed under postoperative supervision.

Anesthesia Time Units

The minutes of anesthesia must be converted by the carrier into time units as follows:

- For anesthesiologists, each ten (10) minutes of anesthesia time equals one (1) time unit and each minute over a time unit has a value of one-tenth (1/10) time unit.
- For CRNAs or AAs, each fifteen (15) minutes of anesthesia time equals one (1) time unit and each minute over has a value of one-fifteenth (1/15) time unit.

Note: One (1) hour and fifteen (15) minutes of anesthesia is equivalent to seventy-five (75) minutes of anesthesia.

Physical Status Modifiers

Anesthesia services must warrant additional reimbursement for units based upon the injured worker's condition and the complexity of the anesthesia service provided.

A physical status modifier must be determined by the provider (CRNA or anesthesiologist only) in order to rank the injured worker's condition.

Additional reimbursement must be based on the unit value for the specific physical status modifier, as assigned by the CPT® manual.

A physical status modifier is required for reimbursement of anesthesia bills.

Physical Status Modifiers		Unit Value
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

Difficult or Qualifying Circumstances

Anesthesia services that are provided under particularly difficult circumstances may warrant additional reimbursement for unit values based on unusual events. Listed below are the specific qualifying circumstances, as assigned by the CPT® manual, that impact the anesthesia services provided.

These procedure codes are not to be reported alone but are reported as additional procedure codes. The listed unit value must be added to the base value units to calculate the reimbursement. List each of the following codes below the primary anesthesia procedure code on the billing form.

Code	Descriptor	Unit Value
99100	Anesthesia for patient of extreme age, under one year and over seventy	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions (specify)	2
	All Others	0

Calculation of Anesthesia Reimbursement

Select the applicable anesthesia procedure code and note the base value from the fee schedule.

Determine the time units based on provider type. Determine any additional units that are justified by the physical status modifier and qualifying circumstances. Add the base value, time units, physical status modifier, and any applicable qualifying circumstances to determine total anesthesia value.

Multiply the total anesthesia value by the conversion factor (CF) of $29.49 to obtain the total anesthesia reimbursement.

Base Value (BV) + Time Units (TM) + Physical Status modifier units + Qualifying Circumstances Units = Total Anesthesia Units

MRA = Total Anesthesia Units x $29.49 (CF)

Procedures Listed as BV with No TM

Certain anesthesia services do not have a listed time value component. The reimbursement method for an anesthesia service that does not have time units associated with the anesthesia base value is as follows:

- Select the applicable anesthesia procedure code and base value from the fee schedule;
- Determine any additional units that are justified by the physical status modifiers or qualifying circumstances;
- Add the base value, physical status modifier, and any applicable qualifying circumstances to determine total anesthesia value; and
- Multiply the total anesthesia value by the CF of $29.49 to obtain the total anesthesia reimbursement.

Base Value (BV) + Physical Status Modifier units + Qualifying Circumstances Units = Total Anesthesia Units
MRA = Total Anesthesia Units x $29.49 (CF)

Note: Reimbursement for CRNAs and AAs must be limited to eighty-five percent (85%) of the total anesthesia reimbursement allowance for an anesthesiologist for any procedure that has no TM units.

Medical Direction of CRNA/AA by Anesthesiologist

Reimbursement must be made only to the anesthesiologist for the direct supervision of anesthesia services which are provided by the anesthesiologist and billed under the name and license number of the physician.

Reimbursement must be made to an anesthesiologist for providing medical direction, including pre-operative and post-operative evaluations or consultations to a CRNA/AA.

Reimbursement for a CRNA/AA requiring medical direction by an anesthesiologist must be:

- According to an agreed upon contract price; or
- Fifty percent (50%) of the anesthesia reimbursement.

Reimbursement for medical direction by an anesthesiologist must be:

- According to an agreed upon contract price; or
- Fifty percent (50%) of the anesthesia reimbursement.

Reimbursement must not be made to either the anesthesiologist or the CRNA/AA until the carrier has received and reviewed the medical bills and anesthesia reports from both providers.

Special Requirements

Anesthesia services must include the CPT® code and the "P" code (physical status modifier), which corresponds with the procedure.

Anesthesia providers must enter the date of service and the 5-digit qualifying circumstances code, which corresponds with the procedure performed, if applicable.

Medical direction must be identified by the anesthesiologist by adding the HCPCS Level II® modifier QY to the anesthesia procedure code.

The HCPCS Level II® modifier QK must be appended to the anesthesia code when the medical direction requires more than one concurrent anesthesia procedure.

When medical direction is required, the CRNA or AA must be identified by appending the HCPCS Level II® modifier QX to the anesthesia procedure code. The

CRNA or AA must provide their Florida Department of Health (DOH) license number.

When a CRNA provides anesthesia services, the CRNA must provide their DOH license number.

Note: See subsection 69L-7.730(2), F.A.C.

Anesthesia Performed by the Operating Surgeon

When an operating surgeon provides regional or general anesthesia for a surgical procedure that he or she performs, modifier 47 is appended to the appropriate procedure code to indicate that the operating surgeon performed the anesthesia. No additional reimbursement is calculated when the operating surgeon bills with the "P" code (physical status modifier).

An operating surgeon cannot report time units in the calculation of anesthesia reimbursement requested on the medical bill. Reimbursement must be for the base value (BV) multiplied by the anesthesia conversion factor (CF) only for the anesthesia service rendered.

Reimbursement must be:

- According to an agreed upon contract price; or
- Base Value x $29.49 (CF) for CPT® codes in the anesthesia section of CPT®.

Conscious Sedation

Refer to the CPT® manual for information on conscious sedation codes.

Post-Operative Pain Management

Pain management may be performed pre-operatively, intra-operatively, or post-operatively.

A copy of the surgeon's order for post-operative pain management and, a copy of the anesthesia provider's separate procedural report, must be submitted to the carrier for reimbursement.

Reimbursement is made for post-operative pain management, when performed by an anesthesia provider or other health care provider who is not the operating surgeon.

Biofeedback Services

Requirements for Reimbursement

Reimbursement for the collection and interpretation of biofeedback data digitally stored and downloaded must be included in the reimbursement to the health care provider for the basic biofeedback service.

The written interpretation of the digitally stored biofeedback results must be signed and dated by the health care provider and maintained in the medical record.

Limitations to Biofeedback Services

Reimbursement for biofeedback training must be limited to twelve (12) visits following the date of injury.

Note: This biofeedback training limitation does not include individual psycho-physiological therapy incorporating biofeedback training by any modality with psychotherapy.

Dental Services

Reimbursement to Dentists and Oral Surgeons

Reimbursement is made to a dentist or oral surgeon for dental procedures or services.

Note: Emergency oral surgery does not require prior authorization. The carrier must be notified by the health care provider no later than the close of the third state of Florida business day after emergency treatment.

Dental Codes and Descriptions

Dentists must use the dental guidelines, codes, and descriptors from the CDT® or the D codes in the HCPCS Level II® for dental procedures.

Oral Surgery Services

Oral Surgeons must use the CPT® guidelines, codes, descriptors, and modifiers for oral and maxillofacial surgical services.

Oral Surgeons must refer to the label block **Reimbursement of Multiple Surgical Procedures** under **Surgical Services** in this Manual for information regarding reimbursement for multiple surgical procedures, as well as other surgical reimbursement guidelines.

Temporo-Mandibular Joint (TMJ) Services

Dentists must use a combination of the dental guidelines, codes, and descriptors from the CDT® manual and the D codes from the HCPCS Level II® manual.

To receive reimbursement:

- Dentists who provide TMJ services may use a combination of CPT® codes and dental codes from the CDT® or HCPCS Level II®; or
- Dentists must refer to the physical medicine section of this Manual for information on physical medicine reimbursement policies.

Electrodiagnostic Medicine

Determining Medical Necessity

The referring physician must determine the medical necessity of an Electromyography (EMG) or a Nerve Conduction Study (NCS). Only a physician must determine the frequency of testing or the necessity of repeat testing.

Reimbursement Policy for EMG

Only health care providers specifically qualified by state regulations to perform EMG must be reimbursed.

Reimbursement must include the testing, interpretation of the studies, and a written report of the findings.

When the initial evaluation and management service and needle EMG testing are performed during the same visit, reimbursement must be made for both services.

When the follow-up evaluation and management service and needle EMG testing are performed on the same day, reimbursement must be made for both services only if the documentation validates the medical necessity for the follow-up evaluation and management service.

When needle EMG testing is performed in a hospital or other facility, reimbursement must be made for an interpretation and report of the testing. Modifier 26 must be appended to the appropriate procedure code for reimbursement.

Nerve Conduction Studies

A health care provider, specifically qualified by regulations in his or her state, must determine the nerves to be tested based on specific clinical findings during the examination performed at the time of the study.

Reimbursement Policies for NCS

When the initial evaluation and management service and the NCS are performed during the same visit, reimbursement must be made for both services.

When a follow-up evaluation and management service and the NCS are performed on the same day, reimbursement must be made for both services only if the documentation validates the medical necessity of the follow-up evaluation and management service.

A technologist under the direct supervision of the physician may perform an NCS. However, the services must be reimbursed under the supervising physician's name and DOH, or out-of-state, license number.

Reimbursement must include the testing, interpretation of the studies, and a written report of the findings.

Evaluation and Management Services

Office Visits

A carrier must reimburse a health care provider for evaluation and management services (new or established patient visits).

A new patient means an injured worker who is:

- New to the health care provider;
- An established patient who has not received service for more than three (3) years from the same health care provider; or
- An established patient with a new compensable injury or illness and a new date of accident.

Note: Reimbursement is limited to one (1) evaluation and management visit per day at the level of care documented by the health care provider.

Home Visit Services

A health care provider must not be reimbursed for home visits unless prior authorization from the carrier has been received.

A health care provider must bill for a home visit using the appropriate evaluation and management procedure code.

Consultations

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation or management of a specific problem is requested by another physician or other appropriate resource. A physician must be reimbursed for consultations, confirmatory consultations, and follow-up consultation services.

Reimbursement for consultations must include a review of all submitted medical records, paper and non-paper; a physical examination of the injured worker; and a written report.

Telemedicine

Telemedicine services are defined in Section 456.47, F.S. Telemedicine services require authorization by the carrier.

The exceptions to carrier authorization for telemedicine are:

- Emergency services and care, defined in section 395.002, F.S.; and
- One (1) initial evaluation, diagnosis, and treatment by a treating provider at the time of an acute injury when initiated by the employer or the employer's designee to determine appropriate care.

Telemedicine visits are reimbursed using the same MRA as a face-to-face visit. The type of service is determined by and must be reimbursed according to the place of service of the injured worker.

All limitations for Evaluation and Management and other medical services found in this Manual apply to Telemedicine.

Home Health Agency Services

Definition

Home Health Services are medically necessary services which can be effectively and efficiently provided in the place of residence of an injured worker. Services may include home health visits (nurses and home health aides), therapy services (speech therapy, physical therapy, occupational therapy), and the coordination of authorized home medical equipment.

Home Health Visit Definition

A Home Health Visit is an encounter between a registered nurse, licensed practical nurse, home health aide, or licensed therapist employed by a Home Health Agency and an injured worker at his or her place of residence.

A Home Health Visit is not limited to a specific length of time but is defined as an entry into the injured worker's place of residence for the length of time needed, as prescribed by the health care provider to provide medically necessary nursing,

home health aide, or therapy service(s). An injured worker's residence cannot be a facility such as a hospital, a nursing facility, or a rehabilitation facility of any type.

General Policies

A Home Health Agency must have a signed order outlining the Home Health Plan of Care from the authorized physician in order to obtain carrier authorization of home health services. The Home Health Plan of Care must be renewed every thirty (30) calendar days and submitted to the carrier for authorization.

Staff Skill Level

A Home Health Agency must provide staff with the skill level designated and appropriate for each service prescribed in the health care provider's order and approved plan of care, as authorized by the carrier.

Staff Substitutions

If a staff absence occurs, the Home Health Agency is responsible for providing and assuring that appropriate staff substitutions are made.

Licensure or discipline of the staff substitutions must be equivalent to, or above, the discipline level specified in the plan of care.

Reimbursement

The carrier must reimburse the Home Health Agency according to an agreed upon contract price.

Independent Medical Examinations (IME)

Requirements for Reimbursement

Components of a physician's Independent Medical Examination, or IME, must include:

- The review of applicable paper medical records;
- The review of applicable non-paper medical records; and
- The examination of the injured worker with production of a written report.

Reimbursement for IME

IME services are reimbursed according to an agreed upon contract price in accordance with section 440.13(5), F.S., if an injured worker fails to appear for an IME scheduled by the employer or carrier, without good cause, and fails to advise the physician at least 24 hours before the scheduled date for the examination that he or she will not appear, the physician may bill his or her cancellation or no-show fee to the carrier.

Note: The procedure code for an IME is 99456.

Medications

General Policies

Medicinal drugs, commonly known as legend, or prescription drugs, dispensed to treat an injured worker must be ordered by a health care provider.

Medicinal drugs are dispensed, stored, and sold only by a pharmacist licensed under Chapter 465, F.S., or a licensed dispensing practitioner according to the provisions in section 465.0276, F.S.

Reimbursement for Administration of Injectable Medication

Reimbursement is made for the administration of injectable medications.

- Reimbursement must be made using CPT® or HCPCS Level II® codes.
- Reimbursement for administration of an injection may include a local anesthetic, as directed by the drug manufacturer.
- Reimbursement for administration of multiple injections is limited to one initial drug administration service code reported per patient per day, unless protocol requires otherwise.

Reimbursement for the administration of an injection must be either:

- The listed MRA in the fee schedule for the first reported drug, or according to an agreed upon contract price; and
- Fifty percent (50%) of the listed MRA in the fee schedule for each additional drug, or according to an agreed upon contract price.

Reimbursement for Injectable Medications

Reimbursement to health care providers for injectable medications provided in the office must be billed and reimbursed based on the actual units administered to the patient and must be:

- The listed MRA in the fee schedule; or
- According to an agreed upon contract price; or
- If no MRA or no agreed upon contract price, then twenty percent (20%) above the acquisition invoice cost of the injectable medication; based on submission of the name, strength, and dosage of the medication, vaccine, or toxoid; and submission of the acquisition invoice.

Medications via Infusion Pumps

A special reimbursement provision is allowed for identification of the loading dose of medication(s) administered via infusion pump.

Reimbursement for the loading dose of the medication must be:

- The listed MRA in the fee schedule; or
- According to an agreed upon contract price; or
- If no MRA or no agreed upon contract price, then twenty percent (20%) above the acquisition invoice cost and requires submission of the acquisition invoice.

Manufacturer's Shipping and Handling will be reimbursed at the actual cost on the invoice.

Prescription Medications

The reimbursement for prescription medications must be made pursuant to paragraph 440.13(12)(h), F.S.

Note: Florida workers' compensation unique procedure codes:

- DSPNS: Legend or prescription drugs dispensed by a licensed dispensing practitioner (See subsection 69L-7.720(1), F.A.C., for the specific use of this code).
- COMPD: Compounded drugs dispensed by a pharmacist or physician (See subsection 69L-7.720(1), F.A.C., for the specific use of this code).

Compounded Drugs and Convenience Kits

Compounded drugs and convenience kits are identified as a specialty services under section 440.13(3)(i), F.S.

Reimbursement for Compounded Drugs

Reimbursement is:

- According to an agreed upon contract price; or
- The total of the AWP for all components + one dispensing fee ($4.18) = Reimbursement.

Medications with No MRA

Reimbursement for medications with no MRA listed in the fee schedule must be:

- According to an agreed upon contract price; or
- If no agreed upon contract price, then twenty percent (20%) above the actual cost of the medication based on the submission of documentation, which includes:
  1. The name, strength, and dosage of the medication dispensed to the injured worker; and
  2. The acquisition invoice cost of the item billed which includes unit(s) of supply and unit pricing information.

Over the Counter Drugs

A dispensing practitioner must use the NDC number and submit an invoice to the carrier that provides the name, dosage, package size, and cost of the drug(s), including applicable manufacturer's shipping and handling.

Reimbursement must be made to a pharmacist for dispensing over-the-counter drugs at the pharmacist's usual charge for the drug.

Reimbursement must be made at the health care provider's charge or at an amount not to exceed twenty percent (20%) above the actual cost of each drug furnished.

Non-Reimbursable Drugs and Supplies

Reimbursement must not be made for oral vitamins, nutrient preparations, or dietary supplements, or medical food pursuant to section 440.13(3)(k), F.S.

Health Care Provider Supplies

Reimbursable Materials and Supplies

Materials and supplies not incidental to a service or a procedure must be reimbursed using the specific HCPCS Level II® supply codes.

When a more specific HCPCS Level II® code is not available for reimbursable materials and supplies, the health care provider must use the HCPCS Level II® miscellaneous supply code A9999 and submit the following documentation:

- A detailed description of the supply or material and the unique medical need for the injured worker; and
- A copy of the acquisition invoice cost of the item billed, including unit(s) of supply and unit pricing information.

Shipping and handling cost must be documented on the same sales invoice submitted with the bill which includes the material or supply.

Reimbursement must be:

- The listed MRA in the fee schedule; or
- According to an agreed upon contract price; or
- If no MRA or no agreed upon contract price, then twenty percent (20%) above the cost of the material(s) or supply(ies) based on submission of the acquisition invoice cost that substantiates the health care provider's purchase.

Shipping and handling are reimbursed separately at the provider's actual cost.

Materials and Supplies Not Separately Reimbursed

Materials and supplies that are necessary to perform a procedure or service are included in the reimbursement for the procedure or service and must not be reimbursed separately.

Home Medical Equipment and Medical Suppliers

Guidelines and Requirements

The guidelines and requirements in this Manual are the same for Home Medical Equipment (HME) providers and medical suppliers.

General Requirements

Medical supplies and HME must be prescribed by a health care provider and may be provided to an injured worker by an HME provider through rental or purchase.

Reimbursement for HME Providers and Medical Suppliers

Reimbursement is made to licensed HME Providers and Medical Suppliers.

HME providers or medical suppliers must provide the carrier with a copy of the health care provider's original order with the medical bill when requesting reimbursement.

Reimbursement must be made by the carrier to an HME provider or medical supplier for rental or purchase of HME and supplies ordered or prescribed by a health care provider according to an agreed upon contract price.

The carrier:

- May rent the item from the HME provider or medical supplier for the injured worker;
- May write a provision in the agreed upon contract that when the amount received by the HME provider or medical supplier from the rental payments equals the purchase price, the item will become the property of the carrier or injured worker; or
- May purchase the item from the HME provider or medical supplier.

Limitations for HME and Supplies

All additional HME and medical supplies require prior authorization by the carrier as a requirement for reimbursement.

No reimbursement must be made for HME or medical supplies that are automatically supplied or refilled by the supplier.

Note: When a specific code is not available to describe the item provided, bill HCPCS Level II® code A9999. The carrier may provide additional, specific billing instructions at the time of authorization.

The HME provider or medical supplier is not required to provide invoices with the bill to document the acquisition costs of supplies and equipment.

Ophthalmologic Services

General Reimbursement Requirements

Reimbursement for ophthalmologic services must be made for all medically necessary services. Prior authorization from the carrier is required unless the condition is an emergency.

Ophthalmological services with no MRAs in the fee schedule must be reimbursed according to an agreed upon contract price.

Glasses, Contacts, or Frames

Reimbursement must only be made for glasses, contact lens, or frames of comparable quality to the original when they are damaged, lost, or required for treatment as a result of an injury or surgery to correct an injury.

Permanent Impairment Ratings (PIR)

Providers Eligible to Determine Permanent Impairment Rating

Only a physician licensed by the Chapters listed in section 440.15(3)(b), F.S., must be reimbursed by the carrier for addressing Maximum Medical Improvement (MMI) and the assignment of a Permanent Impairment Rating (PIR).

Reimbursement Components and PIR

The components of a PIR must include an examination that provides:

- The evaluation of an injured worker's condition to establish the MMI date and PIR of zero (0) percent or greater; and
- The systematic completion of the required reporting form, DWC-25, and submission to the appropriate parties in accordance with section 440.15(3), F.S.

The DWC-25 does not replace physician notes or other medical records.

The DWC-25 must be fully completed and must document the method(s) and guide used to assign a PIR.

Reimbursement must not be made for an evaluation and management code on the same date of service as a PIR.

Note: The procedure code for a PIR is the CPT® code 99455.

Psychiatric and Psychological Services

Reimbursement

Reimbursement for psychiatric and psychological services must be made by the carrier to the following health care providers who provide individual psychotherapy services within the scope of state licensure:

- Medical physicians;
- Osteopathic physicians;
- Psychologists;
- Mental health practitioners; or
- Other health care practitioners.

Required Documentation

All psychiatric and psychotherapy procedure codes that are reimbursed based on time with the injured worker must have a beginning and an ending time documented in the medical record.

Individual Psychotherapy Combined with Evaluation and Management Codes

Only a health care provider may be reimbursed for individual psychotherapy in combination with evaluation and management services provided at a therapy session. Documentation must support the services billed.

A health care provider must not be reimbursed for an evaluation and management procedure code on the same day that reimbursement is made for psychotherapy combined with evaluation and management services.

Note: Refer to the CPT® to identify the combined procedure codes.

Multiple Psychotherapy Sessions on the Same Day

When more than one (1) individual psychotherapy session is performed on the same day, only the session lasting the longest period of time must be reimbursed.

Reimbursement for Central Nervous System Testing

Reimbursement must be made for CNS Assessment and Testing when the documentation includes:

- An assessment and administration of a test with interpretation and a written report;
- The number of hours (units of service), supported by the health care provider's documentation, required to perform the assessment and testing; and
- The procedure code used for billing indicates if the service is per hour or is all inclusive.

Behavioral Assessment Interventions

For reimbursement purposes all health care providers must refer to the most specific Health and Behavior Assessment and Intervention procedure codes for health and behavioral interventions.

Radiology

Reimbursable Services

Reimbursement must be made for radiology services including diagnostic radiology (diagnostic imaging), diagnostic ultrasound, and nuclear medicine.

Components of Radiology Reimbursement

Radiology services consist of two (2) components: the technical component and the professional component.

Technical Component: modifier TC
When the technical component (the actual performance of the radiological test and the production of the hard copy film(s)) is reported separately, the service is billed by adding the HCPCS Level II® modifier TC to the procedure code when requesting payment.

Professional Component: modifier 26
When the professional component (physician interpretation of radiological test results) is reported separately, the service is billed by adding the HCPCS Level II® modifier 26 to the procedure code when requesting payment.

Global Services

Global services are reimbursed for both the technical and the professional components of a radiological procedure or service. The unmodified 5-digit procedure code is used to identify a global service inclusive of the professional service and the technical component of providing that service.

Reimbursement Policies

Reimbursement must not be made for a professional component (modifier 26) billed in the following situations:

- A professional component billed by a physician for x-rays taken and interpreted by another physician and reviewed during an IME, medical visit, or consultation;
- A professional component billed by a physician for reviewing x-rays during an emergency department or hospital visit when the x-rays are interpreted by the radiologist at the hospital; or
- A professional component billed by a physician who is not the health care provider that reviewed, interpreted, and signed the radiology report.

Independent Radiology Facilities

Reimbursement must be made to an independent radiology facility for the technical component of the service by appending the HCPCS Level II® modifier TC to the 5-digit procedure code.

No reimbursement must be made for the professional component of a service to an independent radiology facility. Only a technical component may be reimbursed to an independent radiology facility.

The professional component must be billed separately by the health care provider that interprets the radiology exam.

Thermography

Reimbursement Requirements

The carrier will not authorize a physician to perform thermography any earlier than forty-five (45) calendar days after the date of accident unless the documentation of medical necessity is submitted to the carrier along with the request for authorization prior to rendering the service.

Thermography Limitations

Reimbursement for thermography is limited to one (1) body area; either major or limited.

- Major body areas. (The following areas include all views.)
    1. Head,
    2. Cervical spine and upper extremities, and,
    3. Lumbosacral spine and lower extremities.
- Limited body areas. (The following areas include all views.)
    1. Thoracic spine, and
    2. Any portion of a major area.

Transcutaneous Electrical Neurostimulators (TENS)

Reimbursement

Reimbursement is made for transcutaneous electrical neurostimulators.

Reimbursement must be:

- The listed MRA in the fee schedule; or
- According to an agreed upon contract price; or
- If no MRA or no agreed upon contract price, then twenty percent (20%) above the health care provider's documented cost when the TENS unit is purchased.

A copy of the health care provider's acquisition invoice must be submitted with the bill to substantiate the health care provider's cost.

Training Sessions for TENS

Reimbursement must be made to a health care provider for furnishing training to an injured worker on the application and use of a TENS unit.

Reimbursement is limited to four (4) training sessions per approved TENS unit. The carrier must designate the number of training sessions authorized.

Physical Medicine and Rehabilitation Services

General Information

Physical medicine and rehabilitation services must be considered as covered treatment only when such care is given based on a health care provider's referral or prescription and when the medical necessity for such services is supported in the health care provider's evaluation and in the physical medicine plan of care.

Physical Medicine Plan of Care (DWC-25)

Physical medicine services (i.e., modalities and therapeutic services, physical reconditioning, or interdisciplinary rehabilitation programs) must be documented on the DWC-25, submitted to the carrier by the physician, and supported in the evaluation with a physical medicine plan of care, regardless of the location where the services are rendered or whether rendered by a physician or another practitioner.

If the carrier questions the appropriateness of the therapy listed in the plan of care, the carrier must contact the physician to obtain the rationale for the ordered therapy prior to authorization.

The physician is responsible for providing the carrier the documentation of medical necessity for the therapy in order to avoid unnecessary delays in obtaining authorization for treatment or in initiating therapy.

Reimbursable Services

Carriers must reimburse health care providers for the following physical medicine and rehabilitation services provided to injured workers for a compensable injury/illness:

- Modalities and therapeutic procedures applied to acute injuries to reduce symptoms, restore function, and return the injured worker to work.
- Physical reconditioning focused on injuries requiring intensive physical reconditioning services to restore the injured worker to pre-injury level of physical health and function. The goal must be for the worker to return to a job and/or become physically reconditioned.
- Interdisciplinary rehabilitation programs covering a variety of services that are coordinated, outcome focused, and directed at the injured worker's needs to increase functioning or return to work.

Failure to provide requested documentation which supports objective, relevant medical findings, may result in the health care provider being ineligible for reimbursement.

Reimbursement of Services

Reimbursement must only be made for physical medicine, therapeutic procedures, modalities, and rehabilitation services up to six (6) months after the date of accident, based on a signed order or referral from a health care provider.

Exceptions to Limitations

Exceptions may be made to the above limitation when the health care provider provides documented, objective, relevant medical findings that demonstrate the following:

- The injured worker has a specifically defined, relevant clinical dysfunction, consistent with the patient classifications outlined on the DWC-25 as well as in this Manual, that is reasonably expected to respond to the requested physical medicine modalities or procedures; and
- The injured worker does not conform to either the Level II or Level III patient classifications based on specific documentation of the following:

    1. No systemic musculoskeletal deficit (strength, flexibility, endurance, coordination) or substantive functional loss requiring an intensive physical reconditioning program;
    2. No behavioral or psychological issues that present a substantive factor in the rehabilitation effort or outcome;
    3. No significant vocational or return to work issues; and
    4. No significant disparity between the injured worker's subjective complaints, response to intervention, and other relevant clinical indicators when compared with documented, objective, relevant medical findings.

Service Limitations

Reimbursement for physical medicine services is limited to one visit per day, unless additional visits are authorized by the carrier.

Physical Medicine

Reimbursement is made to a health care provider for physical medicine.

Reimbursement must include the testing, an interpretation of the studies, and a written report of the findings.

Reimbursement for an initial evaluation by a health care provider must be billed as an evaluation and management service.

Reimbursement for an initial evaluation by a therapist must be based on the complexity of the evaluation. Documentation must support the time spent with the injured worker.

Separate reimbursement must not be made to a health care provider and to a therapist for an evaluation by each on the same date of service.

Reimbursement for an initial evaluation must include the evaluation and a plan of care or treatment.

Documentation of the evaluation and preparation of a plan of care must include at a minimum:

- The evaluation findings, including any functional limitations;
- The proposed therapy, specifying the frequency and duration of services; and
- The anticipated degree of restoration of function with measurable goals.

Physical Medicine Re-Evaluation by a Therapist

Reimbursement must be made for a re-evaluation by a therapist, no more than once every four (4) weeks, when ordered by a health care provider and documented on the DWC-25.

Physical Therapist Assistant and Occupational Therapist Assistant

Therapy services, performed by a physical therapist assistant (PTA) or occupational therapist assistant (OTA), for greater than ten percent (10%) of the total therapy time, must be appended with the appropriate HCPCS Level II® modifier.

Evaluation by an Athletic Trainer

Reimbursement for an initial evaluation by an athletic trainer must be made only after a referral from a health care provider and according to an agreed upon contract price. Documentation must support the level of complexity and the time spent with the injured worker.

Separate reimbursement must not be made to a health care provider and to an athletic trainer for an evaluation by each provider on the same date of service.

Reimbursement for an initial evaluation by an athletic trainer must include the evaluation and a plan of care or treatment.

Re-Evaluation by an Athletic Trainer

Reimbursement must be made for a re-evaluation by an athletic trainer, no more than once every four (4) weeks, when ordered by a health care provider and documented on the DWC-25, and according to an agreed upon contract price.

Evaluation by an Occupational Therapist

Reimbursement for an initial evaluation by an occupational therapist must be made only after a referral from a health care provider.

Documentation must support the level of complexity, and the time spent with the injured worker.

Separate reimbursement must not be made to a health care provider and to an occupational therapist for an evaluation by each on the same date of service.

Reimbursement for an initial evaluation by an occupational therapist must include the evaluation and a plan of care or treatment.

Re-Evaluation by an Occupational Therapist

Reimbursement must be made for a re-evaluation by an occupational therapist, no more than once every four (4) weeks, when ordered by a health care provider and documented on the DWC-25.

Revised Plan of Care

The physician must prepare and submit to the carrier a revised DWC-25 to document the change in care or treatment.

Modalities and Therapeutic Procedures

Reimbursement to a health care provider must be made for the modalities and therapeutic procedures listed in the plan of care with the limitation that no more than four (4) units of service must be reimbursed per visit.

- Codes 97010-97028 must each equal one (1) reimbursable unit of service. The performance of the supervised modality codes is not time-oriented, and each code may only be reported once during the visit.
- Codes 97032-97542 must each equal one (1) reimbursable unit of service for each fifteen (15) minute increments of service performed.
- Code 97150 must be restricted to one (1) reimbursable unit of service per visit.

Manipulative Treatment

Reimbursement to a physician for a manipulative treatment must be limited to:

- One (1) visit per day; and
- The body regions listed in this Manual.

Osteopathic Spinal Manipulation

Reimbursement is made to a physician for osteopathic manipulative treatment to the body regions listed in this Manual.

The body regions are:

- Head
- Cervical,
- Thoracic,
- Lumbar,
- Sacral,
- Pelvic,
- Lower Extremities,
- Upper Extremities,
- Rib Cage,
- Abdomen and Viscera region.

Chiropractic Spinal Manipulations

Reimbursement is made to a chiropractic physician for chiropractic manipulative treatment to the spinal regions listed in this Manual.

The five (5) spinal regions are:

- Cervical region (includes the atlanto-occipital joint);
- Thoracic region (includes the costovertebral and costotransverse joints);
- Lumbar region,
- Sacral region; and
- Pelvic (sacro-iliac joint) region.

Chiropractic Extra-Spinal Manipulations

Reimbursement is made to a chiropractic physician for chiropractic manipulative treatment to the extra-spinal regions listed in this Manual.

The five (5) extra-spinal regions are:

- Head (including temporomandibular joint; excluding atlanto-occipital);
- Lower extremities;
- Upper extremities,
- Rib cage (excluding costotransverse and costovertebral joints); and
- Abdomen.

Acupuncture

Providers Eligible for Reimbursement

Reimbursement for acupuncture must be made to a health care provider specifically licensed by the DOH to diagnose and treat with acupuncture.

Reimbursement Requirements

Reimbursement for acupuncture or electro-acupuncture service is based on fifteen (15) minute increments of face-to-face contact with the injured worker during a session.

Each treatment session consists of only one (1) initial fifteen-minute (15 minute) increment.

If additional time is required to be reported, use the appropriate add-on codes.

Reinsertion of the acupuncture needle(s) is required for the use of acupuncture add-on codes.

Acupuncture Limitations

Reimbursement is limited to one (1) visit per day.

Orthotics and Prosthetics

Reimbursement Policies

All prosthetic or orthotic devices must be prescribed by the authorized health care provider.

Reimbursement must be made only to licensed orthotics or prosthetics providers, occupational therapists, or physical therapist providers for custom fabricated orthotic or prosthetic device(s).

Orthotic Fitter and Orthotic Fitter Assistant

Orthotic Fitters and Orthotic Fitter Assistants may be reimbursed for services provided within the scope of their licensure that are prescribed by a licensed health care provider.

Tests and Measurements

General Policies & Limitations

Reimbursement to a health care provider must be limited to one (1) visit by an injured worker per thirty (30) calendar days for tests and measurements to a selected body area or number of areas unless a different interval is outlined in the patient's plan of care. A variation to the standard limitation for tests and measurements must be ordered by the authorized physician and approved by the carrier.

Reimbursement for Tests and Measurements

Reimbursement for tests and measurements must include a written report of the testing results.

Reimbursement must be made for range of motion measurements.

Physical Reconditioning Services

Providers Eligible for Reimbursement

Reimbursement for physical reconditioning services must be made only to an occupational therapist, physical therapist, or athletic trainer.

Authorization

Reimbursement must only be made for carrier authorized physical reconditioning based on a signed order from the health care provider.

Physical reconditioning services must be authorized by the carrier prior to initiation and must not begin any earlier than thirty (30) calendar days after the injured worker's date of accident.

Physical Reconditioning Assessment

Reimbursement for a physical reconditioning assessment and written report must be determined from the number of hours reported by the health care provider to perform the assessment and is limited to eight (8) hours for the physical reconditioning assessment and report.

Reimbursement for Physical Reconditioning

Reimbursement for a physical reconditioning program is limited to a program lasting no longer than sixty (60) hours during a six (6) week period, which includes a physical reconditioning assessment.

Multiple Therapies by the Same Provider

Reimbursement must be made for a physical reconditioning program when the services are provided alone, along with, or subsequent to modalities and procedures by the same authorized occupational therapist or physical therapist.

Limitations

Reimbursement must be made to a therapist or athletic trainer for only one (1) physical reconditioning program for an injured worker per date of accident, unless authorized by the carrier for an exacerbation of the injury or surgical intervention, as documented by the authorized health care provider.

Reimbursement for an extension of a physical reconditioning program must be limited to an additional twenty (20) hours during a two (2) week period.

Interdisciplinary Rehabilitation Programs

Reimbursement

Reimbursement must only be made to an interdisciplinary rehabilitation facility for carrier authorized interdisciplinary services based on a signed order from the health care provider.

Exceptions to Policies

Approval beyond the policies provided in this section must be obtained from the carrier, in writing, prior to a health care provider furnishing the service. Any unusual circumstances must be documented and forwarded by the health care provider to the carrier for review before an exception to the policies can be considered and a determination made by the carrier to authorize additional services.

CARF Accreditation Requirements

Reimbursement for Interdisciplinary Rehabilitation Programs must only be made to rehabilitation programs accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), except for a facility operating pursuant to Chapter 395, F.S., as part of a hospital.

Rehabilitation Program services must be provided through a CARF accredited Outpatient Medical Rehabilitation Program, Occupational Rehabilitation Program, or Interdisciplinary Pain Rehabilitation Program.

Work Hardening Programs

Reimbursement for a work hardening program must be made to a facility for the duration of the recommended individualized program.

Refer to the CPT® manual for the applicable procedure codes and information on Work Hardening Programs.

Pain Programs

Reimbursement for an interdisciplinary pain management program must be made to a facility for the recommended time indicated in the injured worker's program plan.

Pain Program Components

The services provided must relate to the physical, psychological, social, functional, and vocational goals of the injured worker's program plan.

Reimbursement for Pain Programs

Reimbursement must be made for biofeedback, physical and rehabilitation medicine services, pharmacy services, psychological and psychiatric services and testing, musculoskeletal services tests and measurements, neuromuscular services tests and studies, and other medically necessary services during the course of the program.

Discharge Report from an Interdisciplinary Program

The facility's program director must determine if the injured worker must be discharged from the work hardening or pain program before completion. If the injured worker has not completed the program and the program director recommends discontinuance of the program, the program director must provide discharge information, including the discharge report, to the injured worker, the carrier, and the authorized physician without charge.

Discharge Report

Upon program completion, a report must be sent by the facility's program director, without charge, to the authorized physician and to the carrier with the final bill. The report must include:

- The injured worker's current clinical status and plan for transition from the program; and
- Return to work recommendations and functional limitations.

Functional Capacity Evaluation

Reimbursement for a Functional Capacity Evaluation (FCE) must be made at any time in the clinical continuum, as long as the evaluation protocol matches the scope and specificity of the clinical situation and referral question(s).

Requirements for FCE

All FCE protocols must be evidence-based. Test design and written interpretation must, at a minimum, focus on identifying associated functional loss, limitations, or restrictions and the correlation to work-related clinical dysfunction (i.e. correlate impairment with disability).

Reimbursement must only be made when a physical therapist or occupational therapist is directly or actively involved with the testing protocol, although additional professional personnel may be involved as well.

Reimbursement for FCE

A health care provider is reimbursed for an FCE. The reimbursement for FCE includes a written program plan and a written report.

The provider must provide the results of the evaluation and recommendations to the injured worker, the carrier, and the authorized physician without additional charge.

Reimbursement for an FCE must be made only when a physical therapist or occupational therapist is directly and actively involved with the testing protocol, although additional professional personnel may be involved as well.

Surgical Services

General Reimbursement Information

General reimbursement information from an authoritative resource is used to determine any limitations or reductions from the MRAs in the fee schedule. All procedure codes having indicators for multiple surgery pricing rules, bilateral surgery pricing rules, assistant at surgery, co-surgeon, team surgery, and information are found in an authoritative resource, such as the National Physician Fee Schedule Relative Value File, copyrighted by the American Medical Association. The Relative Value File is available from the American Medical Association, AMA Plaza, 330 N. Wabash Avenue, Suite 39300, Chicago, IL 60611-5885, or by calling 1-800-621-8335. These indicators must be used to determine reimbursement by the Division.

Global Surgical Package

Reimbursement for a surgical package (global reimbursement) must include the provision of certain services before and after surgery. Examples of these services include:

- The immediate preoperative visit;
- Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia;
- The surgical procedure;
- Immediate postoperative care, including dictating operative notes and talking with the family and other physicians;
- Writing orders;
- Evaluating the patient in the post-anesthesia recovery area;
- Postoperative follow-up care; and
- The time period for routine follow-up care related to the surgical procedure is listed in the Follow-Up Days (FUD) column in the fee schedule.

    1. Reimbursement for a procedure code with a ZZZ designation for the global period must be the same as the other procedure code that is billed in conjunction with this "add-on" procedure code.
    2. Reimbursement for a procedure code with a YYY designation in the global period must be set by the carrier.

Note: The MRA to a physician for surgical procedures can be found in the fee schedule.

Services Reimbursed in Addition to Global Package

Reimbursement must be made for other services in addition to the surgical package only in the following situations:

- The preoperative visit is the initial visit made by the surgeon, when an evaluation is necessary to prepare an injured worker for an unscheduled surgery and when there is a need to establish the reason for a particular type of surgery;
- The preoperative visit by the surgeon is a consultation for unscheduled surgery;
- The preoperative services are not part of the usual preparation for the particular surgical procedure; or
- The services are to treat complications, exacerbations, recurrences, or other diseases and injuries. Documentation substantiating the medical necessity of the additional services rendered must be submitted with the medical bill.

Surgery Performed During Post-Op Period

Reimbursement for surgical services must be made when an additional surgery is performed during the postoperative period of another surgical procedure.

Reimbursement for normal postoperative care must run concurrently and must be made according to the separate FUD periods listed with the MRAs, unless it is a procedure code with the YYY designation. For these codes, the FUD period must be set by the carrier.

Assistant Surgeon

Reimbursement for an assistant surgeon must be twenty-five percent (25%) of the physician MRA. The services provided must be identified by appending the modifier 80 to the specific procedure code.

Non-Physician Surgical Assistants

Reimbursement must be made to a non-physician surgical assistant for surgical services. Non-physician surgical assistants include physician assistants, advanced practice registered nurses, and registered nurse first assistants.

The surgical procedure code(s) must be appended with the HCPCS Level II® modifier AS to identify services rendered by a non-physician surgical assistant at surgery.

Reimbursement for Non-Physician Surgical Assistants

Reimbursement must be made for non-physician surgical assistants performing surgical services. Reimbursement must be seventy-five percent (75%) of twenty-five percent (25%) of the physician MRA, when the carrier has determined:

- The non-physician meets state licensure requirements; or
- During a medical emergency, a physician was not available to assist at surgery.

Procedure codes having indicators for multiple surgery pricing rules, bilateral surgery pricing rules, assistant at surgery, co-surgeon, team surgery, and other reimbursement information must be utilized for determining reimbursement for all procedure codes. These indicators must come from an authoritative resource, such as the National Physician Fee Schedule Relative Value File, copyrighted by the American Medical Association. The Relative Value File is available from the American Medical Association, AMA Plaza, 330 N. Wabash Avenue, Suite 39300, Chicago, IL 60611-5885, or by calling 1-800-621-8335. These indicators must be used to determine reimbursement by the Division.

Two Surgeons *Distinct Parts*

Reimbursements must be made to two (2) surgeons during the same operative session for performing *distinct parts* of a surgical procedure.

Reimbursement to each surgeon must be:

- According to an agreed upon contract price; or
- Sixty-two and one-half percent (62.5%) of the listed MRA.

The services provided must be identified by the same procedure code with modifier 62 appended.

Two Surgeons *Separate Procedures*

Reimbursement must be made to two (2) surgeons for rendering *separate* surgical procedures during the same operative session. The services must be identified by different, unmodified procedure codes.

Reimbursement is made to each surgeon.

Note: Reimbursement must not be made to either surgeon until the carrier has received and reviewed each surgeon's bill and individual operative reports.

Surgical Team

Reimbursement for a surgical team must be made according to an agreed upon contract price.

Each team member must identify the specific procedure(s) they provided by appending modifier 66 to the procedure code(s).

Note: Reimbursement must not be made until all surgical bills and individual operative reports are received and reviewed by the carrier.

Reimbursement for Multiple Surgical Procedures

Reimbursement must be made for surgical procedures when more than one (1) procedure is performed at a single operative session.

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

The primary, or most significant, procedure must be reported first.

Each additional procedure code must be listed separately and reported with a modifier 51.

Reimbursement for the primary surgical procedure must be:

- According to an agreed upon contract price; or
- The MRA.

Reimbursement for additional surgical procedure(s) must be:

- According to an agreed upon contract price; or
- Fifty percent (50%) of the MRA.

Note: Designated add-on procedure codes, listed in the CPT® manual, are exempt from using modifier 51 and the multiple surgery pricing reduction rules.

Reimbursement for Procedures Listed as Bilateral

Bilateral procedures that are listed as "bilateral" in the CPT® descriptor must be designated by the five-digit procedure code only and are exempt from modifier 50. Reimbursement must be:

- According to an agreed upon contract price; or
- The MRA.

Reimbursement for Bilateral Procedures Not Listed as Bilateral

Procedures performed bilaterally that do not contain the word "bilateral" in CPT® require a modifier to identify they were performed bilaterally for proper reimbursement. These require the use of the five-digit procedure code on one line in conjunction with modifier 50.

Reimbursement for a bilateral procedure code that does not include the word "bilateral" in the descriptor must only be made when the payment policy indicators from an authoritative resource, such as the National Physician Fee Schedule Relative Value File, allows bilateral reimbursement.

Reimbursement must be:

- According to an agreed upon contract price; or
- One hundred and fifty percent (150%) of the MRA, unless otherwise stated in this Manual.

Reimbursement for Bilateral Procedures as Multiple Surgery

Reimbursement for these bilateral, multiple surgery codes must be according to the multiple surgery discount rules.

- The primary procedure code listed on the first line without modifier 51;
- Additional procedure code(s) using modifier 51 to indicate multiple procedures performed during the same operative session; and
- Bilateral procedure code(s), using modifier 50 in the first modifier position, followed by modifier 51 in the second modifier position, where appropriate.

Note: Add-on procedure codes, listed in the CPT® manual, are exempt from using modifier 51 and from the multiple surgery pricing reduction rules.

Reimbursement for Bilateral Procedures Performed Unilaterally

When a procedure is listed in the CPT® as a bilateral procedure, but is performed unilaterally, the procedure must be identified with a modifier 52.

Reimbursement must be either:

- According to an agreed upon contract price; or
- Fifty percent (50%) of the MRA.

Terminated Procedures

Reimbursement of a terminated surgery requires documentation that specifies the following:

- Reason for termination of surgery;
- Services, reported by CPT® code, that were performed;
- Supplies provided;
- Supplies not provided that would have been provided if the surgery had not been terminated;
- Time spent by the health care provider in each stage, e.g. pre-operative, operative, and post-operative;
- Time that would have been spent in each of these stages if the surgery had not been terminated; and
- Modifier 53 must be added to the procedure code(s) to identify the circumstances under which the services were terminated.

Reimbursement for Terminated Procedures

Terminated Procedures must be reimbursed as follows:

- No reimbursement must be made for a procedure that is terminated either for medical or non-medical reasons before the pre-operative procedures are initiated by staff.
- Reimbursement must be fifty percent (50%) of the amount allowed for the procedure(s), according to the policies in this Manual, if a procedure is terminated due to the onset of medical complications after the patient has been taken to the operating suite, but before anesthesia has been induced.
- Payment must be fifty percent (50%) of the amount allowed for the procedure(s), according to policies in this Manual, if a medical complication arises which causes the procedure to be terminated after induction of anesthesia.

Appendix A: Forms

The following Forms and Form Completion Instructions are incorporated by reference in Rule 69L-7.720, F.A.C.

Forms Incorporated by Reference for Medical Billing, Filing, and Reporting:

- Form DFS-F5-DWC-9 (CMS-1500 Health Insurance Claim Form, Rev. 02/12)
- Form DFS-F5-DWC-10 (Statement of Charges for Drugs and Medical Equipment & Supplies Form)
- Form DFS-F5-DWC-11 (American Dental Association Dental Claim Form, Rev. 2012)
- Form DFS-F5-DWC-25 (Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form, Rev. 01/31/2008)
- Form DFS-F5-DWC-90 (UB-04 CMS-1450, Uniform Bill, Rev. 2006)

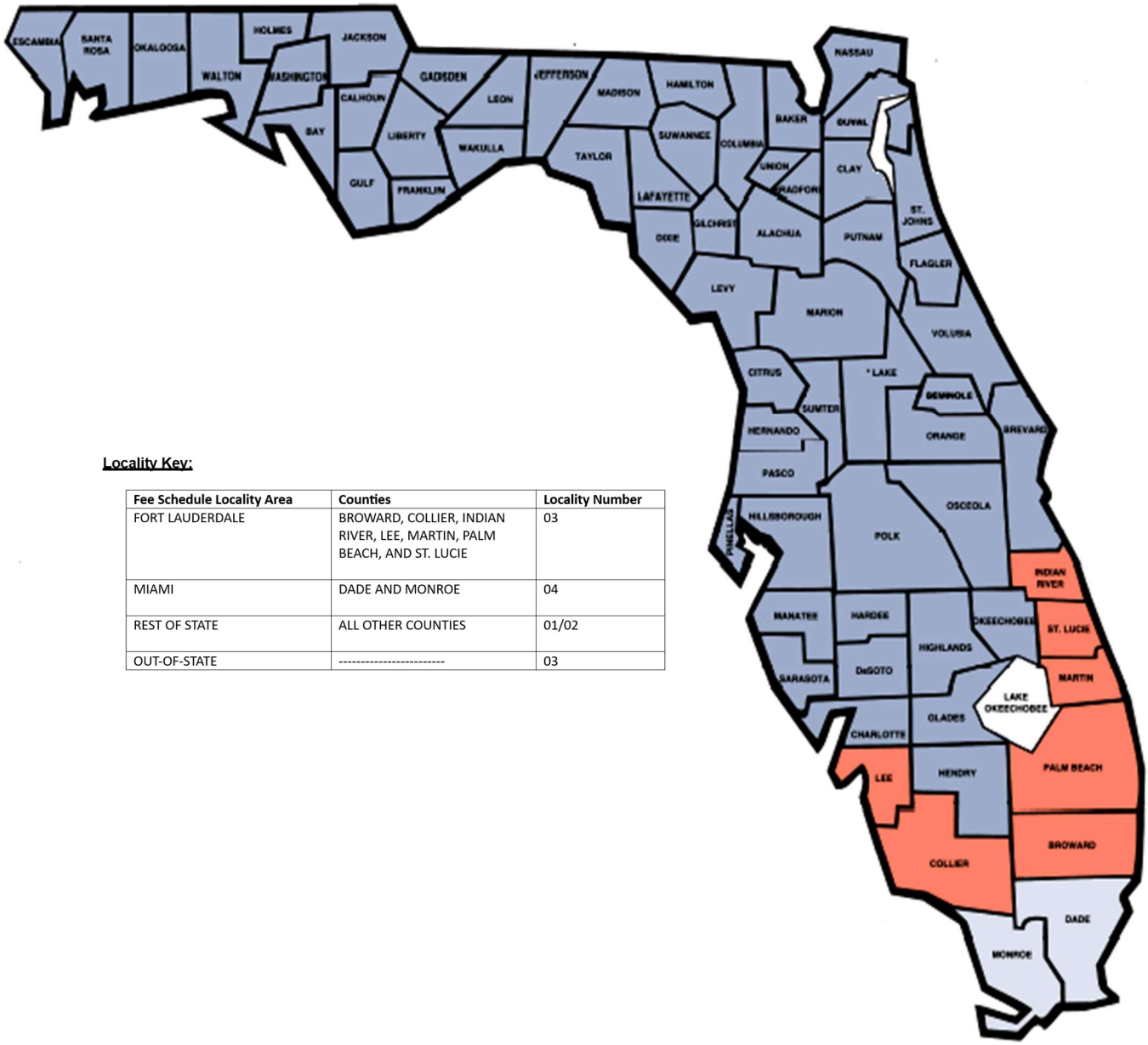
Form Completion Instructions are available at the following DWC's website link:

https://www.myfloridacfo.com/Division/WC. Click on "Forms", then click on "Chapter 69L-7."

Appendix B: Definitions

1. **Division or DWC** means the Division of Workers' Compensation of the Department of Financial Services as defined in section 440.02, F.S.
2. **Home Medical Equipment** is defined in section 400.925(6), F.S.
3. **Home Medical Equipment Provider** is defined in section 400.925(7), F.S.
4. **Emergency Care and Services** means emergency services and care as defined in section 395.002, F.S.
5. **Health Care Provider** means a provider as defined in section 440.13(1)(g), F.S.
6. **Home Health Agency** means an agency as defined in Chapter 400, Part III, F.S.
7. **Maximum Reimbursement Allowance (MRA)** means the specifically listed maximum dollar amount for reimbursement of medical service(s) rendered to an injured worker by a health care provider.
8. **Medically Necessary or Medical Necessity** means any medical service or medical supply that meets the criteria in section 440.13(1)(k), F.S.
9. **Medical Record** means patient records maintained in accordance with the form and content required under Chapter 395, F.S.
10. **Physician** means a physician as defined in section 440.13(1)(p), F.S.
11. **Telemedicine** means those medical services that are defined in Section 456.47, F.S.

Appendix C: Medicare Locality Key and County Map



Locality Key:

Fee Schedule Locality Area	Counties	Locality Number
FORT LAUDERDALE	BROWARD, COLLIER, INDIAN RIVER, LEE, MARTIN, PALM BEACH, AND ST. LUCIE	03
MIAMI	DADE AND MONROE	04
REST OF STATE	ALL OTHER COUNTIES	01/02
OUT-OF-STATE	----------	03