Florida Workers' Compensation

Reimbursement Manual for Hospitals

Rule 69L-7.501, F.A.C.

2014 Edition

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Chapter 1 Introduction and Overview

Introduction

All changes made to this Manual are subject to the rulemaking procedures outlined in Chapter 120, Florida Statutes.

Approved changes to the Manual will be sent out as electronic updates via the Division of Workers' Compensation e-Alert system. An update can be an approved change, addition, or correction to the guidelines. Updates will be available under 'Publications' immediately proximal to the affected Manual on the DWC web site, www.myfloridacfo.com/Division/wc/.

It is important that hospitals and insurers read the updated material and file it in the Manual. Both parties have a responsibility for certain duties when filing or paying Workers' Compensation medical bills for treatment of injured employees.

E-Alert System

The Division has an electronic alert system to notify subscribers of upcoming news impacting the Workers' Compensation industry, dates of public meetings and workshops. To subscribe to the e-Alerts, please go to the DWC web site, www.myfloridacfo.com/Division/wc/. Look for the "Register" link near the bottom of the page. Once completed, you shall receive e-Alerts whenever they are provided by the Division.

Explanation of the Update Log

The hospital and insurer can use the update log to determine if all the updates to the Manual have been received.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

1.File new Chapters or replacement pages

2.File the new update log

UPDATE NO.	EFFECTIVE DATE
2014-01 New Manual	TBD

Chapter 1 Introduction and Overview, continued

Overview

Introduction

This Chapter introduces the format used for the Florida Workers' Compensation Reimbursement Manual for Hospitals and tells the reader how to use the Manual.

Background

There are 3 different Workers' Compensation Reimbursement Manuals:

- Florida Workers' Compensation Reimbursement Manual for Hospitals, rule 69L-7.501, F.A.C. (Florida Administrative Code) [Hospital Manual]
- Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, rule 69L-7.100 F.A.C. [ASC Manual], and
- Florida Workers' Compensation Health Care Provider Reimbursement Manual [HCP RM], rule 69L-7.020, F.A.C.

Other Applicable Rules

In addition to this Manual, the Florida Workers' Compensation Reimbursement Manual for Hospitals, rule 69L-7.501, F.A.C., also recognizes the following resources:

1. The Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule, 69L-7.710, F.A.C.

2. The Florida Workers' Compensation Health Care Provider Reimbursement Manual, incorporated by reference into rule 69L-7.020, F.A.C.

Legal Authority

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

- Chapter 440, Florida Statutes (F.S.)
- 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.

Chapter 1 Introduction and Overview, continued

Manual Use and Format

Purpose

The purpose of the Florida Workers' Compensation Reimbursement Manual for Hospitals is to furnish providers with the guidelines and procedures needed to submit medical bills to insurers or self-insured employers for services provided in a hospital setting to injured workers and to ensure that insurers receive adequate billing information to make accurate, appropriate payment for services rendered.

This Manual provides descriptions and instructions on how and when to complete forms and other documents that will assist in the bill submission process.

Characteristics of the Manual

Format

The format styles used in the Manuals represent a concise and consistent way of displaying complex, technical material.

Information Block

Information Blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of a subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note: is used most frequently to refer the user to pertinent material located elsewhere in the Manual, related rules, specific statutory authority or to exceptions and limitations to a guideline.

Chapter 1 Introduction and Overview, continued

Manual Updates

Update Log

The first page of each Manual will contain an update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current Manual have been received.

Each update will be designated by an "Update No." and the "Effective Date".

How Changes Are Updated

The Manual will be updated as needed. When a Manual is updated, the resulting new Manual will be replaced with a new effective date throughout at the bottom of each page.

Identifying New Material

New material will be identified by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left and right of the label and the information block.

New Material in an Existing Information Block

A paragraph within an existing information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

A paragraph with new material will be indicated in this manner.

Chapter 2 Program Requirements

Purpose of the Manual

Section 440.13(12)(a), Florida Statutes, provides that "[a]nnually, the Three-Member Panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs." The Florida Workers' Compensation Reimbursement Manual for Hospitals contains the Maximum Reimbursement Allowances (MRA) determined by the Three-Member Panel and establishes policy, procedures, principles and standards for implementing statutory provisions regarding reimbursement for medically necessary services and supplies provided to injured workers in a hospital setting. The policy, procedures, principles and standards in this Manual are in addition to the requirements established by the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule.[1]

This Manual can be obtained free of charge on the DWC web site, www.myfloridacfo.com/Division/wc/, or purchased in hard copy from the Department of Financial Services, Document Processing Section, at 200 East Gaines Street, Tallahassee, Florida 32399-0311.

Unless otherwise specified in this Manual, the terms "insurer" and "carrier" are used interchangeably and have the same meanings as defined in section 440.02, F.S., and may also refer to a service company, third party administrator (TPA) or other entity acting on behalf of an insurer for the purposes of administering workers' compensation benefits for its insured(s). The insurer shall be held accountable for all actions taken by a service company, TPA, or other entity acting on its behalf when adjusting, reimbursing, disallowing or denying reimbursement to hospitals.

[1] Chapter 69L-7.710, Florida Administrative Code.

Chapter 2 Program Requirements, continued

Fraud Statement

Any hospital who 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 will satisfy the requirement for all claims submitted to the claims-handling entity for the calendar year in which the attestation is submitted.

Billing and Reporting

Hospitals and insurers shall comply with the requirements of the Workers' Compensation Medical Services Billing, Filing, and Reporting Rule 69L-7.710, F.A.C., which includes the reporting requirements of the Florida Medical EDI Implementation Guide (MEIG).

Additional billing, reporting and documentation requirements specific to requesting reimbursement for surgical implants when used in an inpatient hospital setting are set forth in Chapter 5 of this Manual.

Hospital Responsibilities

Hospitals shall provide to the insurer additional form completion requirements or supporting documentation beyond those required in rule 69L-7.710, F.A.C., which the insurer may require for a reimbursement determination, when the insurer informs the hospital in writing at the time hospital services are authorized.

Insurer Responsibilities

Insurers shall inform in-state and out-of-state hospitals of the specific reporting, billing and submission requirements of rule 69L-7.710, F.A.C., and provide the specific address for submitting the hospital bill.

Chapter 3 Utilization Control

Authorization of Non-Emergency Services and Care

A hospital shall obtain authorization from the insurer prior to providing any non-emergency medical treatment, care or attendance for a patient's work-related injury or condition.

A hospital shall record the authorization in the injured employee's medical record or in the hospital's billing or financial records(s).

A hospital's recorded authorization shall include the following:

- The date(s) on which authorization was requested and received;
- The name of the insurer or its designated entity, and
- The person authorizing the hospital services.[2]

Emergency Services and Care

Emergency services and care, defined in section 395.002, F.S., do not require authorization at the time they are rendered. A hospital that renders emergency care must notify the insurer by the close of the third business day after it has rendered such care. However, when an emergency medical condition requires or results in a health care facility admission, the hospital shall notify the insurer by telephone within 24 hours of the initial treatment.[3]

When it is determined that an emergency medical condition, defined in section 395.002, F.S., does not exist or no longer exists and only non-emergent follow-up examination or services are required or recommended, any related follow-up care or treatment or referral must be expressly authorized by the insurer prior to the provision of the additional treatment or care.[4]

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[2] See Pre-Certification of Length of Stay for additional authorization requirements for inpatient care.
[3] Subsection 440.13(3)(b), Florida Statutes.
[4] Subsection 440.13(3)(c), Florida Statutes.

Chapter 3 Utilization Control, continued

Pre-certification of Length of Stay

When authorizing inpatient admissions, the insurer shall pre-certify the number of hospitalization days for which reimbursement can be anticipated, according to an authoritative resource for length of stay data.

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

Medical record reviews to determine the medical necessity of hospital services may be performed either concurrently during the hospital stay, or retrospectively after discharge.

Note: A retrospective medical record review shall not toll the 45 day time period established to pay, disallow or deny the hospital bill.[5]

[5] Subsection 440.20(2)(b), Florida Statutes.

Chapter 4 Medical Record Release and Copy Charges

Medical Records

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

Mandatory Disclosure

Unless otherwise prohibited by law, and subject to the confidentiality requirements of state and federal law(s), upon request of the Division, Office of Judges of Compensation Claims, employee, employer or insurer, hospitals shall produce any and all medical records, reports, and information of an injured employee relevant to the particular injury or illness for which compensability has been accepted or for which it is necessary to determine compensability.[6]

Copying Charges for Medical Records

An injured employee or injured employee's attorney requesting copies of medical records shall reimburse the hospital for copying charges according to section 440.13(4)(b), F.S., and rule 69L-7.601, F.A.C., and the hospital may charge no more than 50 cents per page for copying the records and the hospital's actual direct costs for X rays, microfilm, or other non-paper records.

No other copy charges or search charges may be charged to the injured employee or the injured employee's attorney as part of the services provided to the injured employee by the hospital.

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

[6] Subsection 440.13(4)(c), Florida Statutes.

Chapter 4 Medical Record Release and Copy Charges, continued

Limits on Copying Charges

The limits on charges apply regardless of whether the retrieval and copying are performed in-house or contracted out for completion by a copy service or other medical record maintenance service, and also apply when the insurer requires hospital medical records submission with a bill in order for payment to be made or for the purpose of an audit or review conducted under Chapter 9 of this Manual.

The above charges apply to all copies of original documents requested by an insurer whether the request for the copies is made before services are rendered or after services are rendered.

The above charges apply to all copies of original documents requested by an insurer whether the copies of documents are sent to the insurer for the purpose of performing an in-house desk audit or review in lieu of an on-site audit or review at the hospital, or whether the request is made in the course of an on-site audit or medical record review, and whether the request for copies is for an entire document or for selected portion(s) of a document.

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

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

Chapter 5 Inpatient Reimbursement Schedules

Reported Charges

Except as otherwise provided in this Manual, charges for hospital inpatient services shall be reimbursed according to the Per Diem Fee Schedule provided in this Chapter or according to a mutually agreed upon contract reimbursement agreement between the hospital and the insurer. The length of hospital stay shall be pre-certified according to the provisions in Chapter 3 of this Manual.

Note: See **Pre-Certification of Length of Stay** in Chapter 3.

Determining Surgical Stay or Non-Surgical Stay

Determination of whether inpatient hospital services are surgical or non-surgical shall be based on the operative status for the ICD-9-CM© (or ICD-10-CM©, if applicable) primary procedure code reported by the hospital in the appropriate Form Locator on the hospital billing form in accordance with rule 69L-7.710, F.A.C.

The operative or non-operative status of the ICD-9-CM© (or ICD-10-CM©, if applicable) primary procedure code shall be determined by reference to the ICD-9-CM© for Hospitals (or ICD-10-CM© for Hospitals, if applicable), copyright American Medical Association and incorporated by reference into rule 69L-7.501, F.A.C.

Except as otherwise provided in this Manual, hospitals shall be reimbursed according to the surgical per diem schedule for each admission wherein the ICD-9-CM© (or ICD-10-CM©, if applicable) primary procedure code is designated as "Valid O.R. procedure".

Note: For bills related to discharge dates occurring on or after October 1, 2014, the hospital may utilize either ICD-9-CM© or ICD-10-CM© procedure codes. However, the hospital shall only use one or the other for any such bill and shall not mix coding between the two versions on the same bill.

Chapter 5 Inpatient Reimbursement Schedules, continued

Per Diem Schedule

If the Total Gross Charge After Implant Carve-Out[7] is $59,891.34 or less, reimbursement shall be determined according to the following per diem allowances:

Inpatient services provided by a trauma center, licensed pursuant to section 395.4025, F.S.:

1. Surgical stay: $3,850.33 per day;
2. Non-surgical stay: $2,313.69 per day.

Note: For a list of Trauma Center contact information, please see the DOH web site, www.doh.state.fl.us.

Inpatient services provided by other acute care hospitals:

1. Surgical stay: $3,849.16 per day;
2. Non-surgical stay: $2,283.40 per day.

- If the charges for any day of hospitalization are less than the applicable per diem allowance established in this Chapter, the hospital shall be reimbursed the per diem allowance for the day(s) rather than the lesser amount charged by the hospital.
- The insurer shall not reimburse a per diem allowance for the day of discharge.
- The insurer shall not disallow a per diem allowance for any day of an inpatient stay unless the documentation in the medical record does not support the medical necessity for each of the estimated number of days that were pre-certified, or the actual length of stay exceeds the estimated days that were pre-certified by the insurer and the medical record does not substantiate the medical necessity for the additional inpatient day(s).

[7] See definition of Total Gross Charge After Implant Carve-Out in Chapter 11 of this manual.

Chapter 5 Inpatient Reimbursement Schedules, continued

Discharge within 24 Hours of Admission

When a discharge occurs within 24 hours of admission to a hospital facility, reimbursement shall not exceed the applicable per diem allowance for a single day, unless the hospital indicates that the injured employee expired within the 24 hours.

If the injured employee expires within 24 hours of admission, the hospital shall be reimbursed either the per diem amount or 75% of billed charges, whichever is greater.

Exceptions to Per Diem

Before calculating the amount of reimbursement for inpatient services according to this Chapter, charges for surgical implant(s) shall be separated out from the total gross charges for which reimbursement is requested. If the Total Gross Charge After Implant Carve-Out is over $59,891.34 reimbursement shall be determined according to the **Stop-Loss Reimbursement** method**.**

Stop-Loss Reimbursement

If the Total Gross Charge After Implant Carve-Out exceeds $59,891.34, the hospital shall be reimbursed seventy-five percent (75%) of the Total Gross Charge After Implant Carve-Out, except as otherwise provided in this Manual.

Reporting Charges for Surgical Implants and Associated Disposable Instrumentation

All hospitals shall report surgical implant charges and associated disposable instrumentation required for the surgical implant according to the National Uniform Billing Committee Official UB-04 Data Specification Manual, National Uniform Billing Manual, incorporated by reference into rule 69L-7.710, F.A.C.

Hospitals shall identify charges for surgical implant(s) and associated disposable instrumentation on the hospital billing form in the required Form Locator by using the designated Revenue Code in accordance and in compliance with the guidelines and definition of "Other Implant" provided in the UB-04 National Uniform Billing Manual.

Reimbursement for surgical implants shall be billed only under Revenue Code 278 when billing for inpatient hospital services, and supplies shall be determined separately according to Chapter 5 of this Manual.

Note: See **Surgical Implant Reimbursement Formula** in this Chapter.

Chapter 5 Inpatient Reimbursement Schedules, continued

Surgical Implant Reimbursement Formula

Reimbursement for surgical implant(s), also referred to as "other implant" by the National Uniform Billing Manual, required during inpatient hospitalization billed under Revenue Code 278 shall be sixty percent (60%) over the manufacturer's acquisition invoice cost for the implant(s).

Reimbursement for the associated disposable instrumentation required for the implantation of the surgical implant shall be twenty percent (20%) over the manufacturer's acquisition invoice cost, if the associated disposable instrumentation is received with the surgical implant and included on the manufacturer's invoice.

Reimbursement for shipping and handling shall be at actual cost shown on the invoice.

Surgical Implants In Addition to Per Diem or Stop Loss

Reimbursement for surgical implant(s) and associated disposable instrumentation shall be in addition to reimbursement of the Total Gross Charge After Implant Carve-Out; whether the charge is reimbursed by the Per Diem Method or the Stop Loss Method.

Note: Contractual arrangements between a hospital and an insurer shall specify the reimbursement amounts for "surgical implants".

Determining Implant Acquisition Cost

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

Chapter 5 Inpatient Reimbursement Schedules, continued

Request for Implant Reimbursement

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

- Certify that the amount being requested for reimbursement is in accordance with the reimbursement policies in this Chapter, or
- Submit a copy of the manufacturer's acquisition invoice(s) for purchase of the surgical implant(s) and associated disposable instrumentation as documentation of the policy above, to the insurer.

Charges billed under the surgical implant(s) Revenue Code that are not accompanied by one of the methods listed above, shall constitute undocumented charges and shall not be reimbursed.

Note: See **Certification of Implant Reimbursement Amount**.

Certification of Implant Reimbursement Amount

Certification of a medical bill that the amount requested for reimbursement for the surgical implant(s) billed under Revenue Code 278 does not exceed sixty percent (60%) over the invoice costs as specified in this Chapter may be submitted as follows:

- By a signed, written statement accompanying the request for implant reimbursement amount when submitting paper claims; or
- According to prior written agreement between the billing hospital and the insurer regarding reimbursement for surgical implant(s); or
- Via the hospital billing form when submitting claims electronically or by paper.

A hospital electing to submit certification of the implant reimbursement amount via the hospital billing form shall place the amount requested for reimbursement in Form Locator 80, which is labeled 'Remarks'. The hospital shall enter "Implants" in the Form Locator immediately preceding the amount of expected reimbursement which is calculated pursuant to this Manual.

Chapter 5 Inpatient Reimbursement Schedules, continued

Verification of Surgical Implant Costs and Charges

The hospital's certification of amounts requested for reimbursement whether by signed statement, by prior agreement or via the hospital billing form in the Form Locator labeled "Remarks", and the hospital's compliance with billing and revenue code specifications in accordance with the National Uniform Billing Manual, incorporated by reference into rule 69L-7.710, F.A.C., shall be subject to verification through audit and medical record review pursuant to Chapter 9 of this Manual.

Upon request by either the Division or by an insurer or its designee to conduct an audit or medical record review, as defined in Chapter 9 of this Manual, the hospital shall produce a copy to the requester or make the original documents available for on-site review, or elsewhere by mutual agreement, such medical record(s) and surgical implant invoice purchasing documentation as requested within thirty (30) days of the request.

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

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

Chapter 6 Outpatient Reimbursement Schedules

Introduction

Pursuant to section 440.13(12)(a), F.S., all compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges for medically necessary services and supplies, except as otherwise specified in this Chapter. The exception is for scheduled outpatient surgery, which shall be reimbursed at 60 percent of usual and customary charges.

Usual and customary charges are reimbursed based on average charges of outpatient hospital bills, by CPT® code and HCPCS® Level II code, in a specific geographic area. Please see Appendix A of this Manual for the adopted geographic modifiers by county and Appendices B and C for a listing of the Base Rates by CPT® code and HCPCS® Level II code for non-scheduled outpatient services and scheduled surgical services.

In the absence of a CPT® or HCPCS® Level II procedure code in the applicable Appendix or a mutually agreed upon contract between the hospital and the insurer/employer, reimbursement shall be made at the applicable percentage of the hospital's usual and customary charge.

In the event that a CPT® code or HCPCS® Level II code is substantially revised due to the creation of a new CPT® code or HCPCS® Level II code or a new CPT® code or HCPCS® Level II code is created in a CPT® manual released subsequent to the applicable CPT® manual incorporated by reference by rule, the hospital may bill and the insurer shall reimburse, subject to any other provision of this manual, statute, or applicable rule, such substantially revised or newly created CPT® code or HCPCS® Level II code at the applicable percentage of the hospital's usual and customary charge, as described above.

Chapter 6 Outpatient Reimbursement Schedules, continued

Outpatient Hospital Reimbursement Method

Except as otherwise provided in this Chapter, outpatient hospital services shall be reimbursed:

- The Base Rate from Appendix B for services that are not scheduled outpatient surgery multiplied by the geographic modifier listed for the county of the location of service from Appendix A (see reimbursement example in the note below); or
- If the applicable CPT® or HCPCS® Level II code is not listed in Appendix B, 75 percent of the hospital's usual and customary charges; or
- According to a mutually agreed upon contract between the hospital and the insurer/employer.

Note: When an admission occurs following emergency room services or immediately subsequent to other non-surgical outpatient services, reimbursement for the hospital services shall be subject to the provisions of Chapter 5 of this Manual.

Geographically modified reimbursement example for service in Pinellas County: CPT® code 72170 in Appendix B is listed as $380.37 and the geographic modifier for Pinellas County from Appendix A is 0.9976, therefore reimbursement would be $379.46 ($380.37 x 0.9976 = $379.46).

Scheduled Surgical Services

Except as otherwise provided in this Chapter, scheduled surgical services shall be reimbursed:

- The Base Rate from Appendix C for the procedures performed multiplied by the geographic modifier listed for the county of the location of service from Appendix A (see reimbursement example in the note below); or
- If the applicable CPT® or HCPCS® Level II code is not listed in Appendix C, 60 percent of the hospital's usual and customary charges; or
- According to a mutually agreed upon contract between the hospital and the insurer/employer.

Hospitals shall make written entry on the hospital billing form to identify whether an outpatient surgery was scheduled or unscheduled.8 The hospital shall enter "Scheduled" or "Unscheduled" in Form Locator 80.

Note: Geographically modified reimbursement example for service in Broward County: CPT® code 29826 in Appendix C is listed at $3,466.19 and the geographic modifier for Broward County from Appendix A is 1.1195, therefore, reimbursement would be $3,880.40 ($3,466.19 x 1.1195 = $3,880.40).

[8] Rule 69L-7.710, Florida Administrative Code.

Chapter 6 Outpatient Reimbursement Schedules, continued

Services in Conjunction with a Surgical Procedure

Radiology and clinical laboratory services that are provided within three days prior to a scheduled outpatient surgery are deemed services provided "in conjunction with a surgical procedure". These services are reimbursed according to the schedule outlined above.

Determining Surgical vs. Non-Surgical Services

Determination of whether outpatient services are surgical or non-surgical shall be pursuant to the CPT® code(s) reported by the hospital on the hospital billing form pursuant to rule 69L-7.710, F.A.C.

Reimbursement as a surgical code procedure applies if the CPT® code reported on the hospital billing form is within the range of 10021-69990 except when the surgical procedure code within the range of 10021-69990 is performed for venipuncture, or to administer parenteral medication(s), or in conjunction with an invasive medical therapeutic or diagnostic procedure such as that requiring placement of a cannula or catheter, or in conjunction with an invasive radiology or laboratory service that includes injection of diagnostic or therapeutic substance(s), with or without contrast media.

For the purpose of determining reimbursement, procedure codes subject to the preceding exceptions shall be considered non-surgical services and reimbursed consistent with the **Outpatient Hospital Reimbursement Method** on the preceding page.

Surgical Implant Reimbursement

Reimbursement for surgical implant(s), also referred to as "other implant" by the National Uniform Billing Manual, and associated disposable instrumentation required during outpatient surgery billed under Revenue Code 278 shall be determined by one of the following methods:

- For those utilized during unscheduled surgeries, surgical implants and associated disposable instrumentation shall be reimbursed seventy-five percent (75%) of the hospital's usual and customary charge; or

- For those utilized during scheduled surgeries, surgical implants and associated disposable instrumentation shall be reimbursed sixty percent (60%) of the hospital's usual and customary charge; or

- According to a mutually agreed upon contract between the hospital and the insurer/employer.

Note: Since there are no CPT or HCPCS level II codes for implants and associated disposable instrumentation incorporated into Appendices B or C, pursuant to the description of usual and customary charges provided in the **Introduction** of this chapter, these items are reimbursed at the applicable percentage of the hospital's usual and customary charge.

Chapter 6 Outpatient Reimbursement Schedules, continued

Observation

Observation is an outpatient hospital service regardless of the location of the injured employee within the facility. Outpatient observation services shall be billed under Revenue Code 0762 in accordance with rule 69L-7.710, F.A.C.

Observation services shall be reimbursed according to the primary reason the injured employee receives care in the outpatient hospital setting; i.e. scheduled surgical care, emergency room services or non-scheduled surgical services.

If an Observation service is subsequently followed by an admission to the inpatient hospital, a written physician's order is required. The entire hospital encounter shall then be billed as an inpatient hospital bill type and reimbursed according to the guidelines of Chapter 5 of this Manual.

Note: Outpatient observation services for each hour in excess of the 23rd hour are not reimbursable according to paragraph 440.13(12)(a), Florida Statutes.

Chapter 6 Outpatient Reimbursement Schedules, continued

Physical, Occupational, and Speech Therapies

All outpatient physical, speech and occupational therapy services shall be reimbursed according to the schedule of MRAs which applies to non-hospital providers per the Florida Workers' Compensation Health Care Provider Reimbursement Manual, rule 69L-7.020, F.A.C.

Chapter 3, General Instructions, and Part C of the Health Care Provider Reimbursement Manual contains MRAs for Physical, Occupational and Speech Therapy services. Section XI of the Health Care Provider Reimbursement Manual provides information for determining the applicable non-hospital provider locality.

1. Insurers shall adjust only outpatient physical, occupational, and speech therapy services identified on the hospital billing form in accordance with rule 69L-7.710, F.A.C., under the following Revenue Codes: 0420-0429, 0430-0439, 0440-0449, 0930-0932.
2. Insurers shall determine the non-hospital provider facility MRA that applies based on the workers' compensation unique code, the CPT code or the HCPCS code reported by the hospital on the hospital billing form.
3. Insurers shall determine the number of units of physical, occupational or speech therapy services reported by the hospital for each procedure code.
4. Insurers shall multiply the non-hospital provider facility MRA in Chapter 3, Part C of the Health Care Provider Reimbursement Manual, by the units of service to determine the outpatient hospital MRA for the specific physical, occupational or speech therapy services.

Note: The provisions of the Physical Medicine and Rehabilitation Services of the Health Care Provider Reimbursement Manual shall also apply to outpatient hospital therapy reimbursement and are hereby incorporated pursuant to rule 69L-7.020, F.A.C.

Chapter 6 Outpatient Reimbursement Schedules, continued

Scheduled, Non-Emergency Clinical Laboratory and Radiology Services

Scheduled, non-emergency clinical laboratory and radiology services shall be reimbursed according to the schedule of MRAs which applies to non-hospital providers found in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, rule 69L-7.020, F.A.C. Chapter 3, General Instructions, and Part C of the Health Care Provider Manual contains the MRAs for radiology and clinical laboratory services, and Appendix C of the Health Care Provider Reimbursement Manual provides information for determining the applicable non-hospital provider locality.

1. Insurers shall adjust only clinical laboratory and radiology outpatient services identified on the hospital billing form in accordance with rule 69L-7.710, F.A.C., under the following Revenue Codes: 0300-0309, 0320-0329, 0330-0339, 0340-0349, 0350-0359, 0400-0409, and 0610-0619.

2. Insurers shall determine the non-hospital provider facility MRA in Chapter 3, Part C of the Health Care Provider Reimbursement Manual that applies to the technical component (TC) of the CPT code or HCPCS code reported by the hospital on the hospital billing form.

3. Insurers shall determine the number of units of service reported by the hospital on the hospital billing form.

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

Chapter 7 Federal and Out-of-State Hospitals

General policy

Except as provided herein, when providing services to injured workers entitled to medical benefits under the Florida Workers' Compensation Law, both federal and out-of-state hospitals shall comply with the Division's rule(s), including the requirements and procedures established in this Manual.

Federal Hospitals

- Federal hospitals are not subject to the MRAs adopted by the Three-Member Panel and set forth in Chapters 5 and 6 of this Manual; and
- Federal hospitals may use their customary billing form instead of the forms required by rule 69L-7.710, F.A.C.

Out-of-State Hospitals

Hospital services provided outside of the state of Florida shall be reimbursed the amount agreed upon by the hospital and the insurer pursuant to obtaining authorization as required by Chapter 3 of this Manual.

If no amount has been pre-approved, the hospital shall be reimbursed the greater of:

- The amount of reimbursement established under the Workers' Compensation statute where the hospital is located; or
- The MRA as determined using this Manual, including the limitations on reimbursement for radiology, clinical laboratory, and physical, occupational and speech therapies.

Chapter 8 Disallowed, Denied and Disputed Charges

Reimbursement for Services Unrelated to the Compensable Injury

Insurers shall not reimburse hospital charges for services unrelated to the treatment or care of a compensable injury except for the treatment to stabilize or maintain the patient's medical status in order to treat the patient's compensable injury or condition.

Physician and Other Practitioner Services

The insurer shall not reimburse a hospital for physician or other recognized practitioner services when billed by the hospital on the hospital billing form.

Proper billing and reimbursement of physician or other recognized practitioner services rendered in any location, including inside a hospital, shall be in accordance with the requirements of the Florida Workers' Compensation Medical Services Billing, Filing and Reporting rule 69L-7.710, F.A.C. and the Florida Workers' Compensation Health Care Provider Reimbursement Manual, rule 69L-7.020, F.A.C.

Disallowance and Adjustment of Itemized Charges

Except when reimbursement is according to the per diem allowances set forth in Chapter 5 of this Manual, the insurer shall disallow or adjust reimbursement for any charges that are not documented in the patient's medical record, are not consistent with the hospital's Charge Master or are for services, treatment or supplies that are not medically necessary:

1. To stabilize or maintain the patient's medical status in order to treat the patient's compensable injury; or
2. For treatment of the patient's compensable injury or condition.

Timely Payment and Notice of Adjustment, Disallowance or Denial

Notwithstanding the insurer's right to disallow charges, the insurer shall comply with the Florida Workers' Compensation Medical Services Billing, Filing and Reporting Rule[9] and section 440.20(2)(b), F.S., that require timely payment, adjustment, disallowance or denial of a hospital bill.

[9] Chapter 69L-7.710, Florida Administrative Code.

Chapter 8 Disallowed, Denied and Disputed Charges, continued

Minimum Partial Payment Required

At any time when an insurer denies, disallows or adjusts payment for hospital charges in accordance with the time limitations and coding requirements established by statute[10] and by rule[11], the insurer shall remit a minimum partial payment of the hospital's charges, which payment shall accompany the Explanation of Bill Review (EOBR). The minimum partial payment required shall be determined as follows:

Per Diem Payments: The insurer shall remit minimum partial payment for total charges less than $59,891.34 pursuant to the applicable per diem rate for each inpatient day for which the hospital obtained pre-certification in accordance with Chapter 3 of this Manual, and for which there is no dispute as to the medical necessity of the hospital day.

Stop-Loss Payments: The insurer shall remit minimum partial payment pursuant to the greater of:

a. The applicable per diem rate for each inpatient day for which the hospital obtained pre-certification in accordance with Chapter 3 of this Manual, and for which there is no dispute as to the medical necessity of the hospital day, plus payment for any itemized charges that are not denied, disallowed or adjusted; or

b. The applicable reimbursement for each of the itemized charges that are not denied, disallowed or adjusted.

Subject to any minimum partial payments required herein, the insurer shall deny, disallow, or adjust payment for charges included in the Total Gross Charge After Implant Carve-Out that do not correspond to the hospital's Charge Master or are for undocumented or medically unnecessary services or supplies as determined in accordance with Chapter 8 of this Manual. If adjustments to the Total Gross Charge After Implant Carve-Out reduce the Total Gross Charge After Implant Carve-Out to $59,891.34 or less, minimum partial payment for the Total Gross Charge After Implant Carve-Out shall be pursuant to the applicable Per Diem Schedule.

Outpatient Payments: The insurer shall remit minimum partial payment according to the applicable reimbursement for each CPT or HCPCS Level II or workers' compensation unique procedure codes billed code for each of the itemized charges that are not denied, disallowed or adjusted.

[10] Subsection 440.20(2)(b), Florida Statutes.
[11] Chapter 69L-7.710, Florida Administrative Code.

Chapter 9 Charge Master, Medical Record Review or Audit

Disputing Reimbursement

A contested disallowance or adjustment of payment may be resolved by petitioning the department within forty-five (45) days of receipt of a notice of disallowance or adjustment of payment from the carrier pursuant to subsection 440.13(7), F.S.

Hospital Charge Master

The hospital shall produce, or make available for on-site review when requested by the insurer or its designee pursuant to negotiations between the hospital and insurer or its designee regarding a proposed agreement, the hospital's Charge Master as it existed on any date within the most recent twelve (12) months.

The insurer may elect to request copies, subject to copying charges pursuant to Chapter 4 of this Manual, of relevant portions of a hospital's Charge Master and any medical records for in-house desk audit or review or to conduct an audit or review of original documents on-site at the hospital to verify the accuracy of a hospital's charges, billing practices, or medical necessity and compensability of charges for medical services or supplies.

The hospital shall produce copies of the relevant portions of the hospital's Charge Master and any medical records subject to copying charges according to Chapter 4 of this Manual, or make the original documents available on-site, within thirty (30) calendar days of receipt of the written request from either the Department or an insurer or its designee, as part of an audit or review according to this Chapter.

Exit Interview

At the conclusion of the on-site review of documentation, an exit interview shall be conducted by the insurer, if requested by the hospital, concerning the insurer's findings.

Neither a request nor completion of an on-site record review or audit shall toll the time frame for petitioning the Division for resolution of a reimbursement dispute. See paragraph 69L-31.008(4), F.A.C.

Chapter 10 Hospital Bill Submission and Forms

Forms for Medical Bill Submission

All medical bills for hospital services shall be submitted on the Form DFS-F5-DWC-90.

Completing the Claim Form

The Form DFS-F5-DWC-90 Completion Instructions are available on the DWC web site, www.myfloridacfo.com/Division/wc/.

Provider Use of Codes, Descriptions and Modifiers

Hospitals shall use the codes and descriptions, modifiers, guidelines, definitions and instructions of the referenced CPT®, CDT®, HCPCS®, ICD-9® (or ICD-10®, if applicable), UB-04® Manual or Florida Workers' Compensation Unique Codes, modifiers or other materials referenced in this Manual when billing for services.

The use of HCPCS® Level II codes is allowed only when there is not a more specific CPT® code available for use.

All ICD ® diagnosis codes must be reported at the highest level of specificity according to the ICD ® required number of digits, i.e. ICD-9-CM® to the 5th character and the ICD-10-CM® diagnosis codes to the 7th character when required by the ICD-CM® Manual.

__Note__: For bills related to discharge dates occurring on or after October 1, 2014, the hospital may utilize either ICD-9-CM© or ICD-10-CM© procedure codes. However, the hospital shall only use one or the other for any such bill and shall not mix coding between the two versions on the same bill.

Additional Billing Requirements

In addition to submitting the Form DFS-F5-DWC-90, a hospital must:

- Attach an itemized statement with charges based on the facility's Charge Master; and
- Submit all documentation or certification requested by the insurer in writing at the time of authorization; and
- Bill all professional services provided by hospital-employed physicians, physician assistants, advanced registered nurse practitioners, anesthesia assistants or registered nurse first assistants on the Form DFS-F5-DWC-9; and
- Utilize CPT®, HCPCS® or workers' compensation unique codes or modifiers referenced in the Florida Workers' Compensation Health Care Provider Reimbursement Manual, adopted in rule 69L-7.020, F.A.C., when entering procedure codes and modifiers in Form Locator 44 on the Form DFS-F5-DWC-90.

Chapter 10 Hospital Bill Submission and Forms, continued

Outpatient Hospital Billing Requirement

Hospitals shall bill using the appropriate Revenue Center Code in Form Locator 42. All outpatient hospital bills shall have a Revenue Center code and the appropriate HCPCS® or CPT® code in Form Locator 44, where required pursuant to the UB-04 Manual, unless a Revenue Center Code is billed that does not require a HCPCS® procedure code. The list of Revenue Center Codes that do not require a HCPCS® or CPT® code for outpatient hospital bills is available at the following link :

Outpatient Hospital Revenue Code Programming Document or

http://www.myfloridacfo.com/Division/wc/pdf/edi/Revenue_Code_Programming_Document_for_Outpatient_Hospitals_Revision_E_8.31.10.pdf

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Billing Form Completion Instructions for DWC-90 (UB-04)

Form Completion Instructions for DWC-90 Hospital Claim Form or

http://www.myfloridacfo.com/Division/WC/pdf/DFS-F5-DWC-90%20(UB-04)%20-%20B%20(10282009).pdf

SAMPLE DFS-F5-DWC-90 (UB-04) CLAIM FORM

1 | 2 | 3a PAT. CNTL # | 4 TYPE OF BILL
b. MED. REC. #
5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7

8 PATIENT NAME a | 9 PATIENT ADDRESS a
b | b | c | d | e

10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | a b c d | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI
A B C | 57 OTHER PRV ID

58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.
A B C

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME
A B C

66 DX | 67 A B C D E F G H I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 | 76 ATTENDING NPI QUAL LAST FIRST
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | 77 OPERATING NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d | 78 OTHER NPI QUAL LAST FIRST | 79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC LIC9213257

Chapter 11 Definitions

(1) "Admission" means an injured employee that enters a hospital for medical services when, based on the written order from the treating physician, the injured employee will require specific services for medical care. For purposes of reimbursement, an injured employee is only admitted as:

- Inpatient, or
- Outpatient.

(2) "Authorization" means the approval given to a health care provider by the insurer, self-insured employer or entity representing the insurer or self-insured employer for the provision of specific medical services to an injured employee.

(3) "By Report" means a reimbursement allowance made by the insurer based on specific documentation submitted to the insurer containing information on the complete description of the services, procedures, medical necessity, prevailing charges and reimbursement for clinically similar procedures or cost of the services or supplies.

(4) "Charge Master" means a comprehensive listing that documents the facility's charge for all the goods and services for which the facility maintains a separate charge, with the facility's charge for each of the goods and services, regardless of payer type. The Charge Master shall be maintained and produced when requested for the purpose of verifying usual charges pursuant to section 440.13(12)(d), F.S.

(5) "Division" means the Division of Workers' Compensation of the Department of Financial Services as defined in section 440.02(14), F.S.

(6) "Health Care Provider" means a provider as defined in section 440.13(1)(h), F.S.

(7) "Hospital" means a health care facility licensed under subsection 395.003, F.S.

(8) "Inpatient" means an injured employee who is admitted to a hospital for services when, based on the written admitting order from the treating physician that specifies inpatient status, the injured employee will require at least a 24 hour stay as an inpatient status.

(9) "Itemized Statement" means a detailed listing of hospital services and supplies as described in section 395.301, F.S.

(10) "Medical Record" means patient records maintained in accordance with the form and content required under sections 395.3015, 395.302, and 395.3025, F.S.

(11) "Medical Record Review" means a review of the medical record of the injured employee in order to verify the medical necessity of the services and care as they relate to the itemized statement for a specific bill.

(12) "Observation Services" Observation services are those services furnished on a limited basis on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, regardless of the location in the hospital where the injured employee is placed. Observation services are determined to be medically necessary by the treating physician to evaluate a condition of a patient whose status is outpatient and to determine the need for a possible admission to the hospital as an inpatient.

(13) "Outpatient" means an injured employee who, with the written order of a physician, is admitted to the hospital as an outpatient for diagnosis or treatment.

(14) "Per Diem" means a reimbursement allowance based on a fixed rate per calendar day which is inclusive of all services rather than on a charge by charge basis.

(15) "Physician" means a physician as defined in section 440.13(1)(p), F.S.

(16) "Stop-Loss Reimbursement" means a reimbursement methodology based on billed charges once reaching a specified amount that is used in place of, and not in addition to, per diem reimbursement for an inpatient admission to an acute care hospital or a trauma center.

(17) "Surgical Stay" means an admission for which the ICD® operative status for the primary procedure, reported by the hospital on the hospital billing form, is designated as Valid O.R. Procedure.

(18) "Total Gross Charge" means the sum of all charges entered on the hospital billing form during the covered period identified on the hospital bill.

(19) "Total Gross Charge After Implant Carve-Out" means the Total Gross Charge identified on the hospital bill less the sum of all charges for surgical implants billed pursuant to rule 69L-7.710, F.A.C.

(20) "Trauma Center" means a hospital approved for certification as a trauma center pursuant to section 395.401, F.S.

Appendix A: Geographic Modifier, by County

County	Modifier		County	Modifier
Alachua	1.0163		Lee	1.0132
Baker	0.9789		Leon	0.9703
Bay	0.8764		Levy	0.9266
Bradford	0.9266		Liberty	0.9266
Brevard	1.0149		Madison	0.9266
Broward	1.1195		Manatee	1.0447
Calhoun	0.9266		Marion	0.9331
Charlotte	0.9651		Martin	1.1815
Citrus	0.9266		Miami Dade	1.1160
Clay	0.9789		Monroe	0.9266
Collier	1.0686		Nassau	0.9789
Columbia	0.9266		Okaloosa	0.9743
Desoto	0.9266		Okeechobee	0.9266
Dixie	0.9266		Orange	1.0096
Duval	0.9789		Osceola	1.0096
Escambia	0.9095		Palm Beach	1.0946
Flagler	0.9261		Pasco	0.9976
Franklin	0.9266		Pinellas	0.9976
Gadsden	0.9703		Polk	0.9307
Gilchrist	1.0163		Putnam	0.9266
Glades	0.9266		Santa Rosa	0.9095
Gulf	0.9266		Sarasota	1.0447
Hamilton	0.9266		Seminole	1.0096
Hardee	0.9266		St. Johns	0.9789
Hendry	0.9266		St. Lucie	1.1815
Hernando	0.9976		Sumter	0.9266
Highlands	0.9266		Suwannee	0.9266
Hillsborough	0.9976		Taylor	0.9266
Holmes	0.9266		Union	0.9266
Indian River	1.0024		Volusia	0.9626
Jackson	0.9266		Wakulla	0.9703
Jefferson	0.9703		Walton	0.9266
Lafayette	0.9266		Washington	0.9266
Lake	1.0096			

Appendix B: Outpatient Hospital Services

Subject to modification based on county of service. See Appendix A.

CPT	Base Rate		CPT	Base Rate		CPT	Base Rate
10060	$367.31		36600	$57.31		72100	$489.69
10061	$505.93		51702	$282.79		72110	$805.82
10120	$426.48		59025	$376.36		72125	$2,396.98
11012	$2,160.96		62284	$849.98		72128	$2,199.13
11042	$941.72		62290	$1,443.81		72131	$2,405.64
11730	$478.79		64450	$579.60		72141	$2,436.12
11740	$298.52		64510	$1,248.62		72146	$2,574.79
11760	$522.85		64622	$2,034.44		72148	$2,595.14
12001	$332.35		64623	$1,013.48		72158	$3,592.31
12002	$342.67		64626	$1,614.76		72170	$400.84
12004	$322.55		64627	$600.45		72190	$342.58
12005	$539.56		65205	$279.61		72192	$2,511.66
12011	$322.48		65220	$316.79		72193	$2,925.31
12013	$343.90		65222	$312.22		72220	$462.22
12014	$305.53		70110	$550.73		73000	$391.40
12031	$377.35		70150	$537.51		73010	$414.26
12032	$377.13		70160	$398.11		73020	$328.43
12034	$381.58		70355	$287.98		73030	$455.17
12041	$432.11		70360	$331.42		73060	$408.92
12042	$403.42		70450	$2,128.10		73070	$348.27
12051	$422.76		70480	$2,389.52		73080	$439.57
12052	$398.03		70486	$2,066.55		73090	$392.53
13121	$709.09		70551	$2,551.71		73100	$359.21
13132	$944.93		70553	$3,726.50		73110	$427.18
14040	$861.61		71010	$287.49		73120	$323.46
16000	$218.86		71020	$362.78		73130	$422.01
16020	$284.78		71100	$502.89		73140	$318.08
16025	$361.89		71101	$531.16		73200	$1,673.64
20103	$961.07		71111	$604.68		73500	$345.45
20610	$1,015.45		71120	$447.49		73510	$410.64
23350	$388.43		71250	$2,193.50		73520	$627.95
23650	$503.86		71260	$2,495.31		73550	$436.06
23655	$1,156.79		71275	$3,141.11		73560	$347.87
25246	$411.23		72020	$372.03		73562	$454.11
25605	$649.93		72040	$433.08		73564	$498.32
26765	$1,680.44		72050	$667.91		73590	$421.89
26770	$459.34		72052	$672.71		73600	$322.04
27096	$1,327.73		72070	$510.96		73610	$430.29
29260	$202.46		72072	$511.28		73620	$309.02
29515	$301.87		72074	$570.39		73630	$430.49
36000	$193.61		72080	$520.77		73650	$356.76

Appendix B: Outpatient Hospital Services

Subject to modification based on county of service. See Appendix A.

CPT	Base Rate		CPT	Base Rate		CPT	Base Rate
73660	$311.65		82040	$143.80		84703	$122.10
73700	$1,900.90		82055	$221.64		85007	$51.59
73721	$2,460.05		82150	$165.92		85014	$52.71
74000	$362.71		82247	$172.12		85018	$52.97
74020	$603.98		82248	$68.34		85025	$158.30
74022	$592.30		82310	$45.19		85027	$124.32
74150	$2,943.01		82330	$103.74		85378	$102.88
74160	$2,917.80		82374	$42.65		85379	$167.89
74175	$3,748.35		82375	$79.75		85384	$146.31
74176	$4,058.53		82435	$49.33		85610	$101.79
74177	$4,718.11		82550	$113.56		85651	$130.28
74178	$5,098.00		82553	$188.78		85652	$73.06
76000	$589.71		82565	$53.41		85730	$128.58
76376	$498.85		82607	$140.47		86140	$111.34
76377	$832.53		82803	$294.33		86141	$131.15
76705	$585.01		82805	$288.61		86317	$40.10
76801	$632.40		82947	$53.51		86592	$65.99
76805	$941.09		82948	$20.00		86593	$79.75
76815	$447.52		82962	$24.80		86701	$140.74
76817	$467.95		83036	$124.64		86703	$139.39
76870	$729.28		83050	$42.32		86704	$90.41
78452	$3,718.09		83605	$133.53		86705	$90.20
80047	$247.24		83615	$89.61		86706	$128.23
80048	$220.40		83690	$155.10		86709	$89.72
80051	$163.17		83735	$100.40		86803	$124.64
80053	$326.80		83874	$155.26		86850	$102.47
80061	$223.06		83880	$191.44		86900	$74.47
80074	$323.93		84075	$174.61		86901	$49.23
80076	$264.92		84100	$75.34		87040	$256.18
80100	$72.39		84132	$46.68		87070	$235.72
80101	$126.67		84155	$181.31		87075	$186.69
80104	$308.70		84295	$48.21		87077	$97.89
80196	$169.87		84436	$123.09		87081	$79.00
81000	$89.79		84439	$118.78		87086	$177.53
81001	$113.75		84443	$180.65		87088	$109.85
81002	$37.39		84450	$183.99		87186	$114.58
81003	$86.07		84460	$156.41		87205	$93.37
81015	$31.95		84484	$198.55		87340	$101.57
81025	$122.64		84520	$52.00		87522	$874.28
82003	$255.83		84550	$94.27		90471	$78.30
82009	$69.12		84702	$220.57		90472	$60.67

Appendix B: Outpatient Hospital Services

Subject to modification based on county of service. See Appendix A.

CPT	Base Rate		CPT	Base Rate		CPT	Base Rate
90675	$751.34		95816	$758.43		99291	$1,868.07
90701	$174.89		95819	$832.65		99401	$26.25
90703	$94.97		95860	$176.18		99402	$56.48
90714	$99.44		95903	$153.27		G0289	$2,085.89
90715	$162.67		95904	$139.19		G0378	$101.71
90718	$105.60		95920	$559.48		G0380	$212.06
90732	$154.30		95990	$480.95		G0381	$545.78
90746	$105.18		96118	$274.15		G0382	$917.53
90806	$154.11		96152	$211.94		G0383	$1,292.87
90901	$111.70		96360	$261.69		G0390	$4,433.65
92134	$221.21		96361	$130.46		G0434	$285.67
92250	$279.89		96365	$304.19			
92557	$216.06		96366	$118.10			
92567	$95.64		96367	$148.66			
93005	$258.29		96369	$69.41			
93017	$1,103.87		96370	$61.51			
93041	$106.42		96372	$107.65			
93225	$472.42		96374	$151.98			
93226	$612.64		96375	$134.75			
93306	$1,861.02		96376	$126.62			
93312	$1,915.05		97597	$264.59			
93325	$414.80		97602	$165.99			
93350	$1,881.67		99001	$62.88			
93458	$12,219.99		99070	$217.83			
93798	$159.69		99144	$303.70			
93880	$1,054.23		99183	$2,279.60			
93926	$661.02		99201	$157.57			
93970	$1,006.00		99202	$170.61			
93971	$746.39		99203	$262.54			
93975	$852.57		99204	$281.01			
93976	$661.67		99205	$234.75			
94010	$188.55		99211	$137.11			
94060	$492.15		99212	$149.31			
94240	$345.11		99213	$139.80			
94640	$100.05		99214	$184.96			
94664	$86.33		99215	$177.64			
94720	$325.39		99281	$229.26			
94760	$50.95		99282	$353.33			
94761	$109.13		99283	$620.73			
94762	$248.70		99284	$904.69			
95810	$2,801.51		99285	$1,334.93			

Appendix C: Scheduled Outpatient Surgical Services

Subject to modification based on county of service. See Appendix A.

CPT	Base Rate		CPT	Base Rate		CPT	Base Rate
11012	$2,370.99		29807	$4,048.07		64476	$649.06
11042	$612.78		29822	$3,423.64		64479	$1,433.39
11043	$934.83		29823	$3,859.65		64480	$320.22
11044	$2,159.66		29824	$2,909.30		64483	$1,291.09
11045	$403.17		29826	$3,887.00		64484	$504.09
11760	$2,313.46		29827	$3,915.75		64520	$1,272.60
12001	$253.14		29828	$3,234.15		64718	$3,731.77
12002	$438.64		29846	$4,624.60		64721	$3,056.10
12011	$206.09		29848	$2,463.66		64831	$3,596.91
14040	$2,628.81		29873	$3,178.44		71010	$252.40
15271	$1,047.23		29875	$3,153.38		71020	$313.43
15340	$637.66		29876	$2,962.15		72020	$222.06
16020	$254.42		29877	$3,696.92		72040	$268.56
17250	$136.65		29879	$2,218.68		72100	$278.31
20552	$403.26		29880	$3,610.76		72275	$370.11
20553	$689.37		29881	$3,933.98		73030	$365.55
20605	$1,086.98		29888	$5,880.17		73070	$270.18
20680	$3,717.43		36569	$1,150.80		73080	$370.91
22551	$4,013.36		43239	$1,463.70		73090	$320.16
22845	$2,874.93		49505	$4,621.61		73100	$274.15
23120	$3,383.66		49520	$4,871.66		73110	$370.05
23410	$5,583.40		49560	$3,603.48		73130	$347.09
23412	$4,557.66		49568	$2,539.40		73140	$273.36
23420	$5,070.48		49585	$3,775.18		73560	$273.91
23430	$3,457.31		49587	$3,700.72		73562	$284.58
23700	$2,353.77		49650	$5,479.30		73590	$340.75
24341	$5,825.35		55520	$3,593.28		73600	$275.83
24342	$8,359.69		62264	$1,119.98		73610	$379.58
25000	$2,857.99		62282	$794.72		73620	$308.53
25607	$6,580.21		62310	$1,154.42		73630	$382.66
25608	$5,825.46		62311	$1,059.70		76000	$570.68
25609	$7,380.11		62368	$5,677.78		76001	$718.57
26055	$2,142.83		63030	$7,673.16		76937	$549.21
26418	$2,498.81		63047	$6,281.55		76942	$866.95
26615	$5,505.61		63650	$4,786.33		77001	$766.95
26735	$5,180.91		63685	$4,570.88		77002	$384.90
26765	$3,312.20		64415	$1,177.58		77003	$468.42
28485	$5,613.85		64447	$1,547.25		80047	$157.60
29515	$151.80		64450	$962.38		80048	$164.79
29581	$201.27		64470	$1,501.52		80053	$203.32
29806	$4,749.02		64475	$1,617.29		81001	$89.48

Appendix C: Scheduled Outpatient Surgical Services

Subject to modification based on county of service. See Appendix A.

CPT	Base Rate		CPT	Base Rate		CPT	Base Rate
81003	$66.46		85576	$131.43		87205	$68.69
81025	$93.03		85610	$79.52		87206	$71.55
82565	$43.87		85730	$102.49		87641	$124.40
82947	$26.63		86850	$75.92		88300	$102.90
82948	$17.69		86900	$43.98		88302	$159.18
82962	$19.25		86901	$41.35		88304	$229.92
84132	$49.82		87015	$47.91		88305	$304.79
84295	$42.22		87070	$176.71		88307	$393.80
84520	$42.01		87075	$183.67		88311	$119.38
84703	$123.25		87077	$90.91		99218	$96.88
85014	$38.67		87081	$63.79		99219	$219.53
85018	$34.48		87102	$145.16		99220	$67.48
85025	$122.09		87116	$162.38			
85027	$82.81		87186	$101.75			