JEFF ATWATER FLORIDA'S CHIEF FINANCIAL OFFICER

DIVISION OF WORKERS' COMPENSATION

DWC Medical Services Web Portal

Welcome to the Medical Services Web Portal. The Web Portal allows you to:

- Apply for or Renew Expert Medical Advisor (EMA) Certification (Physicians only)
- View deficiencies on a pending EMA application
- Print a duplicate EMA Certificate
- Update EMA Profile

To enter the system, you must enter your User ID and Password.
If you do not have a User ID, click Create a New Profile
If you have forgotten your Password, click Forgot Password?
If you have forgotten your User ID, click Forgot User ID?

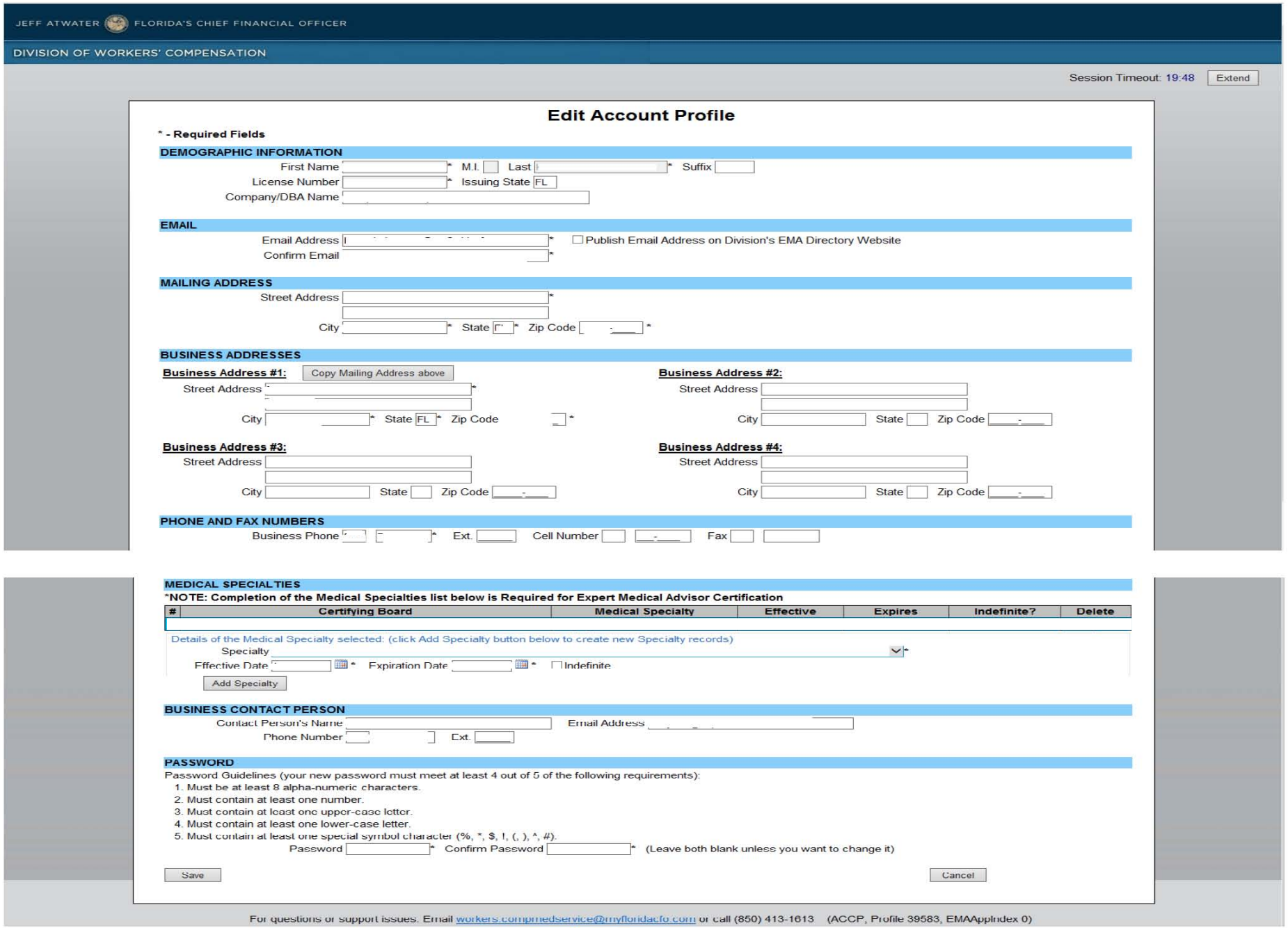
Log into the Web Portal

User ID

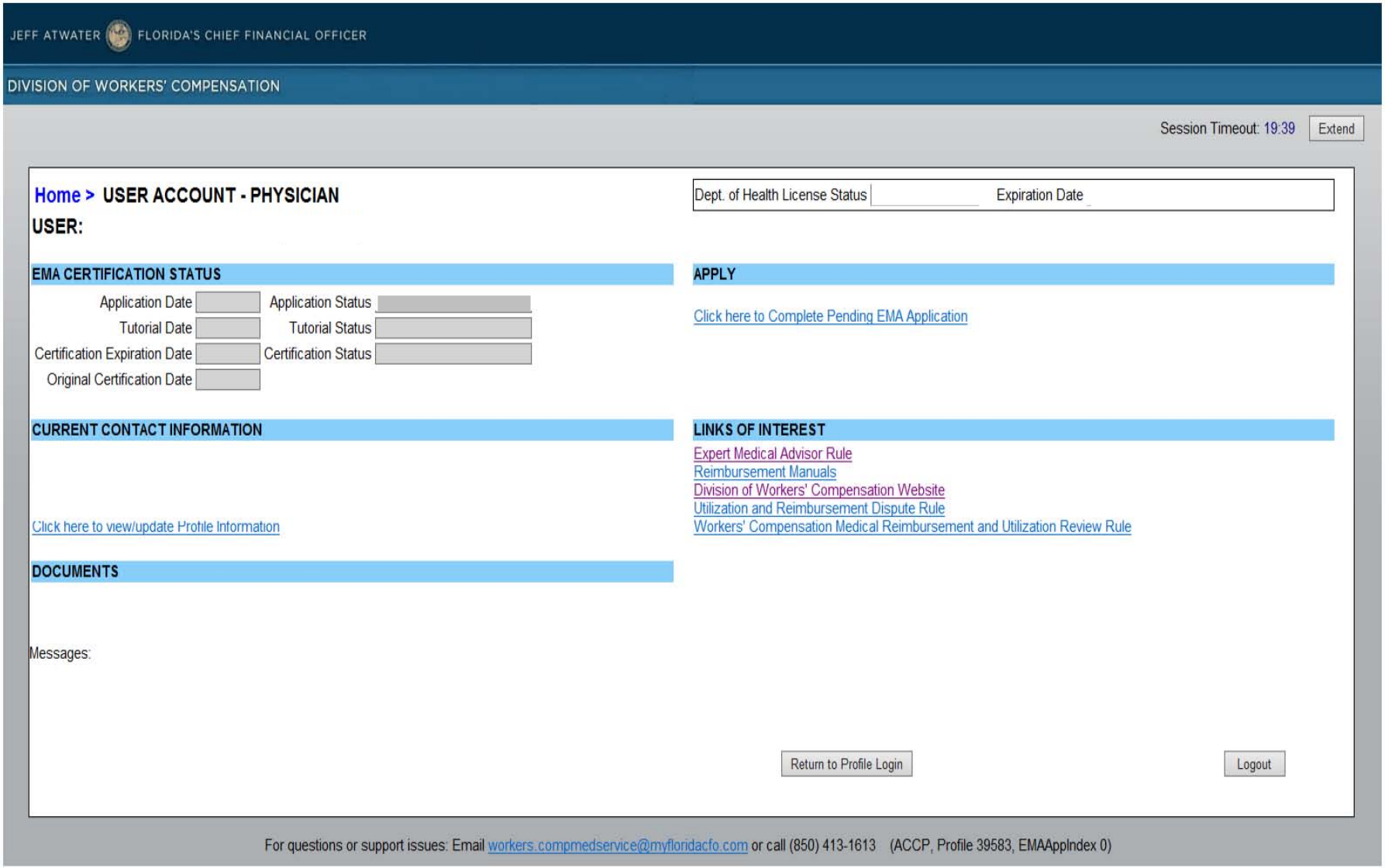
Password

Login Cancel

For questions or support issues: Email workers.compmedservice@myfloridacfo.com or call (850) 413-1613 (ACCP, Profile 0, EMAAppIndex 0)



DFS-F2-2192, Expert Medical Advisor Certification Portal, Rev. 04/17. Adopted in Rule 69L-30.002, F.A.C.



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JEFF ATWATER FLORIDA'S CHIEF FINANCIAL OFFICER

DIVISION OF WORKERS' COMPENSATION

Session Timeout: 19:48 Extend

Expert Medical Advisor Certification

Thank you for your interest in rendering professional expert opinion, as an Expert Medical Advisor (EMA), within the Florida Workers' Compensation health care delivery system.

This EMA portal has been designed to provide an efficient method for licensed and board certified physicians to apply for EMA certification, check the status of a pending EMA application and maintain their physician profile.

Please review steps for this application process before continuing:

Step 1: Review Qualifications for EMA Certification
Step 2: Complete Screening Questions
Step 3: Scan and Upload Required Documentation
Step 4: Complete EMA Tutorial Review
Step 5: Submit EMA Application for review by the Department

Applicants: The Department's Medical Services Section will evaluate your application and supporting documentation to determine if you meet the eligibility requirements for EMA Certification. This process takes approximately one to two weeks. You will be notified via email if any additional information or documentation is needed for further processing of your application. Your application will be considered complete only upon the Department's receipt of all requested information, including required documentation.

If you are unable to scan and upload the required documents, you will still be able to complete this online process. However, required documents must be faxed or mailed to the Department within fifteen (15) calendar days of the application submission date. Incomplete applications will be available online for fifteen (15) calendar days only.

Cancel Continue

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JEFF ATWATER FLORIDA'S CHIEF FINANCIAL OFFICER

DIVISION OF WORKERS' COMPENSATION

Session Timeout: 19:55 Extend

Qualifications for EMA Certification

To apply as an Expert Medical Advisor (EMA), you must meet the following qualifications pursuant to Rule 69L-30, Florida Administrative Code (F.A.C.):

- Hold a valid license issued by the Florida Department of Health (DOH), with "CLEAR/ACTIVE" status; and
- Demonstrate board certification or board eligibility applicable to the specialty for which the applicant seeks certification by submitting proof of current certification or eligibility; and
- Demonstrate experience in assignment of impairment ratings for Florida's injured employees, pursuant to Rule 69L-7.604, F.A.C., within the two year period immediately preceding the date of application by submitting a minimum of two copies of completed Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form (DFS-F5-DWC25) as incorporated in Rule Chapter 69L7.720(1)(d), F.A.C., assigning a permanent impairment rating; and
- Demonstrate experience in performing independent medical examinations pursuant to subsections 440.13(2) or 440.13(5), Florida Statutes (F.S.), by submitting a minimum of two copies of completed Independent Medical Examination Reports for a determination of the appropriateness of medical treatment being recommended or provided to an injured employee or for the injured employee's disability and physical limitations within the two year period immediately preceding the date of application; and
- Demonstrate completion of twenty hours of Continuing Medical Education (CME), specifically related to the field of specialty, within the two year period immediately preceding the date of application by submitting a minimum of twenty CME hours. Completion of courses required for licensure by the DOH addressing Domestic Violence, HIV-AIDS, and Prevention of Medical Errors does not meet CME requirements for certification; and
- Correctly answer 95% of the EMA Tutorial review questions (required only for initial certification).

NOTES:

- **A Physician who has performed services as a Temporary EMA for the Department within the two-year period immediately preceding the date of application for certification shall not be required to submit copies of two DWC-25 forms and two Independent Medical Examination reports.**
- **A Physician applying for renewal prior to or no more than 90 days after the expiration of their most current EMA certification period shall be exempt from completing the EMA Tutorial review questions.**
- **A Physician who, pursuant to a final order, has been found to have engaged in a pattern or practice of overutilization, billing, or standard of care violations pursuant to subsections 440.13(8), (13), and (15), F.S., shall not be certified as an EMA.**

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JEFF ATWATER FLORIDA'S CHIEF FINANCIAL OFFICER

DIVISION OF WORKERS' COMPENSATION

Session Timeout: 19:54 Extend

Screening Questions

○ Yes ○ No	1. Have you ever been disciplined and issued a final order for pattern or practice of overutilization, billing, or standards of care violations pursuant to subsections 440.13(8), (13), or (15) Florida Statutes?
○ Yes ○ No	2. Are you a physician and hold a valid medical license issued by the Florida Department of Health (DOH), with "CLEAR/ACTIVE" status?
○ Yes ○ No	3. Are you board certified or board eligible by one or more of the national specialty boards recognized by the Florida Department of Health?
○ Yes ○ No	4. Have you performed services as a Temporary EMA for the Department with the two-year period immediately preceding the date of application? If you answer yes, please enter the Department Case Number below.
○ Yes ○ No	5. Have you completed a minimum of two Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form (DFS-F5-DWC25 Form) assigning a permanent impairment rating for Florida's injured employees within the two-year period immediately preceding the date of application? (not required if question #4 above answer is yes)
○ Yes ○ No	6. Have you completed a minimum of two Independent Medical Examination reports for a determination of the appropriateness of medical treatment being recommended or provided to a Florida injured employee or for the injured employee's disability and physical limitations within the two-year period immediately preceding the date of application? (not required if question #4 above answer is yes)
○ Yes ○ No	7. Have you completed twenty-hours of Continuing Medical Education (CME), specifically related to the field of specialty, within the two-year period immediately preceding the date of application by submitting a minimum of twenty CMEs? *Completion of courses required for licensure by the DOH addressing Domestic Violence, HIV-AIDS and Prevention of Medical Errors does not meet CME requirements for certification.*
○ Yes ○ No	8. Do you agree to provide consultation or services in accordance with the timetables set forth in Chapter 440, Florida Statutes, and abide by rules adopted by the Department?

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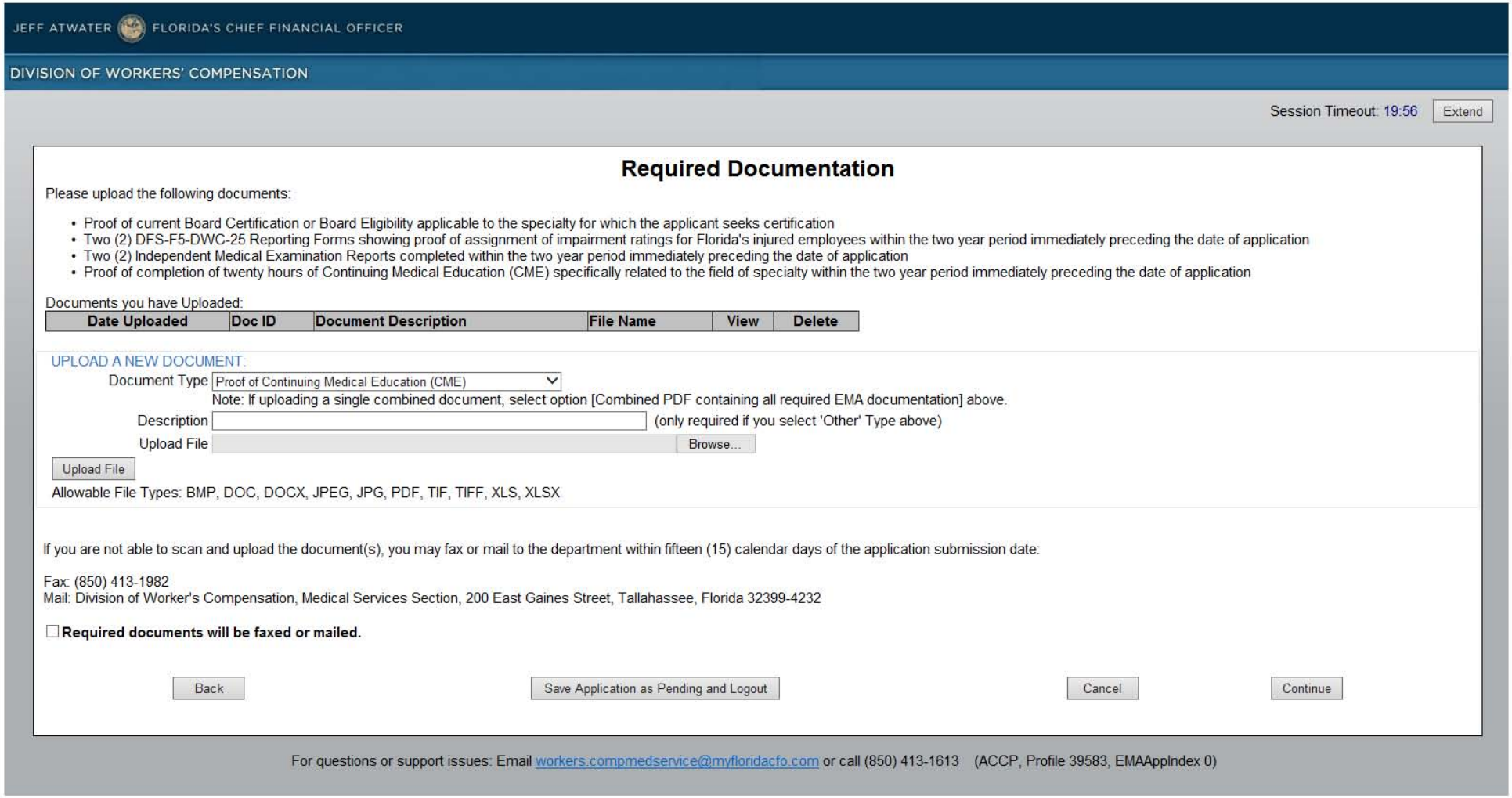

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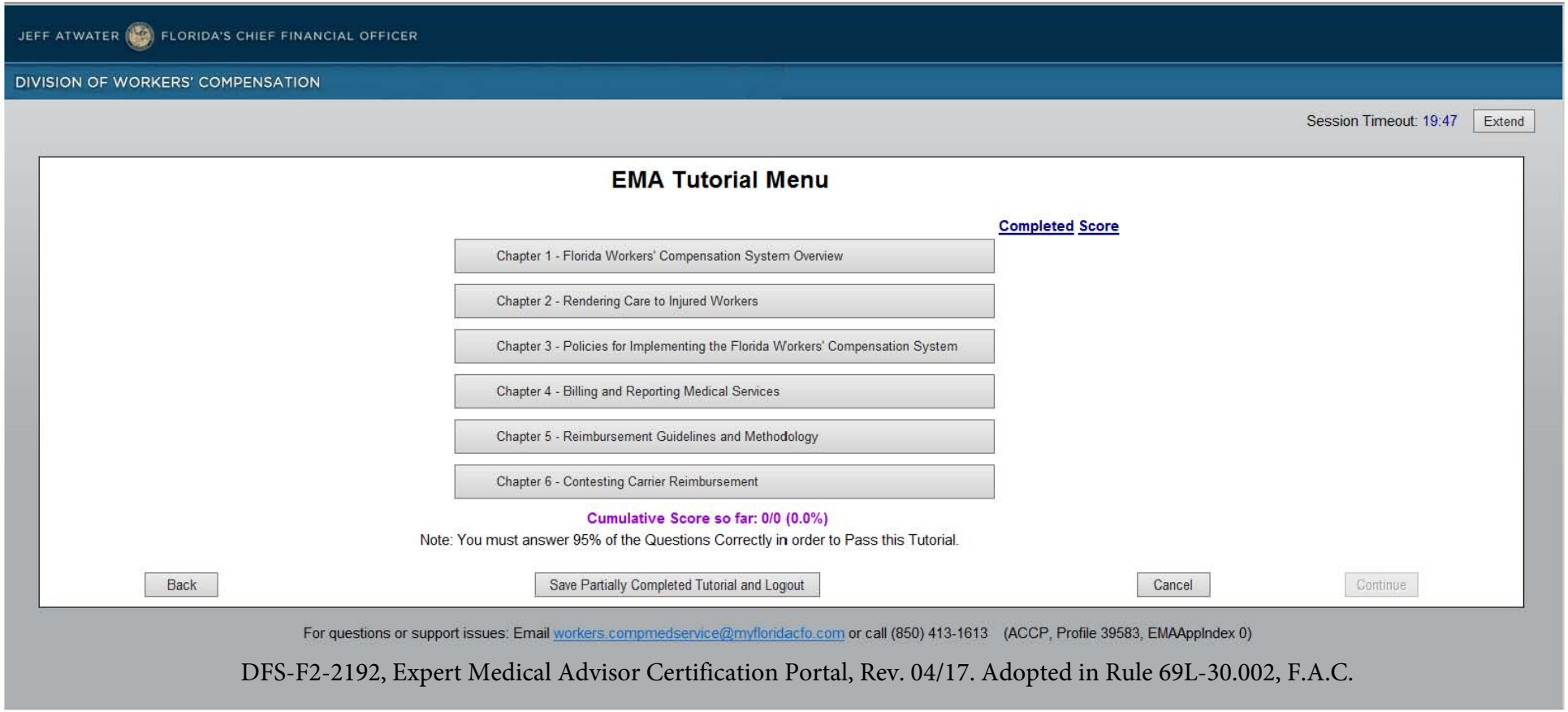

DFS-F2-2192, Expert Medical Advisor Certification Portal, Rev. 04/17. Adopted in Rule 69L-30.002, F.A.C.

Chapter 1 - Florida Workers' Compensation System Overview

Pursuant to s. 440.015, F.S., the statutory intent of the Florida Workers' Compensation law (Chapter 440, F.S.), is to be interpreted:

- To assure the quick and efficient delivery of disability and medical benefits to an injured employee.
- To facilitate the injured employee's return to gainful reemployment at a reasonable cost to the employer.

The provisions of Chapter 440, F.S., establish the roles of the employer, the carrier, and the provider in the Florida Workers' Compensation System. Furthermore, Chapter 440, F.S., grants rule-making authority to the Division to adopt rules for the effective administration of the Florida Workers' Compensation System.

A provider's understanding and familiarity with these statutory provisions and administrative rules are essential to successful participation in the Florida Workers' Compensation System and in rendering prompt and appropriate medical treatment and services.

Role of the Employer

An employer is required to provide workers' compensation coverage for their employees and shall:

- Furnish such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, including medicines, medical supplies, home medical equipment, orthoses, prostheses, and other medically necessary apparatus.
- Provide or authorize initial treatment upon notification of the injury, upon request by the injured employee, or upon request by the provider.

Role of the Carrier

A self-insured employer or a carrier, acting on behalf of an employer (hereinafter "carrier"), is responsible for ensuring that injured employees receive all medically necessary treatment required for a compensable injury or illness. The carrier shall:

- Review all requests for authorization of treatment or referrals for treatment in a timely manner.
- Determine if the treatment recommended or provided is appropriate and consistent with standards of care adopted under the Florida Workers' Compensation System.
- Conduct utilization review to evaluate the appropriateness of the level and quality of treatment recommended or rendered to an injured employee for the compensable condition.
- Determine if an injured employee is making satisfactory progress in recovery as the result of authorized treatment.
- Provide appropriate alternative medical treatment and services when required.

Role of the Health Care Provider

A Health Care Provider (provider) shall render medically necessary treatment and care to the injured employee to facilitate maximum recovery and optimum return-to-work outcomes. To fulfill this requirement, a provider shall:

- Obtain authorization prior to providing treatment to an injured employee or referring an injured employee for specialized services, except when emergency treatment is required.
- Adhere to the standards of care (s. 440.13(15), F.S.) in providing or recommending medically necessary treatment and services.
- Communicate to the carrier the provision of medical treatment and the injured employee's medical status for the timely and appropriate adjudication of a workers' compensation claim.
- Discuss the medical condition of the injured worker with the carrier or the attorney for either the carrier or injured worker.

What is Medically Necessary Treatment?

Medically necessary treatment is defined in s. 440.13(1)(k), F.S., as:

- Any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters.
- The service should be widely accepted among practicing providers, based on scientific criteria, and determined to be reasonably safe.
- The service must not be of an experimental, investigative, or research nature.

Complete Chapter 1 Review Questions Cancel

DFS-F2-2192, Expert Medical Advisor Certification Portal, Rev. 04/17. Adopted in Rule 69L-30.002, F.A.C.

Chapter 2 - Rendering Care to Injured Workers

This chapter discusses the policies related to a provider's obligation to seek authorization from the carrier before rendering or making a referral for medical treatment and services, and to submit treatment reports to communicate the medical status of the injured employee to the carrier and other affected parties.

Also, this Chapter discusses the standards of care with which providers must comply to facilitate the injured employee's maximum recovery with suitable return-to-work outcomes, at a reasonable cost to employers.

A provider who renders medical treatment and services to an injured employee must:

- Be authorized by the carrier to render such treatment and care, except in an emergency.
- Timely notify the carrier when emergency medical treatment and services are rendered.
- Submit treatment reports to the carrier in a format prescribed by the Division.
- Follow the standards of care requirements in s. 440.13(15), F.S., when rendering medical care.
- Address an injured employee's permanent impairment and utilize permanent impairment guides adopted pursuant to Chapter 440, F.S.
- Upon request by the carrier or affected parties, make available information related to the medical status of the injured employee.

Authorization

An injured employee is entitled to all medically necessary treatment for his or her compensable injury. However, the requirements for notifying the carrier and requesting authorization to provide or refer for such treatment depend on whether the treatment is emergency or non-emergency in nature. Section 440.13(3), F.S., specifically addresses requirements related to obtaining authorization for medical treatment and services.

Emergency Treatment

Pursuant to s. 440.13(3)(b), F.S., emergency medical treatment rendered through a certified facility or resulting from a referral for emergency treatment does not require prior authorization from the carrier. As a condition of reimbursement, a provider rendering emergency treatment must:

- Notify the carrier within three (3) business days of any emergency treatment.
- Notify the carrier of a hospital admission within 24 hours of emergency treatment which includes or leads to admission to the hospital.

Non-Emergency Treatment

A provider rendering non-emergency treatment must obtain authorization from the carrier before such treatment is rendered, pursuant to s. 440.13(3)(a) and (c), F.S. A provider must also request authorization to refer an injured employee for treatment. Prior authorization is a condition for reimbursement of non-emergency treatment and services.

Submission of Treatment Plans (DWC-25 Form) and Medical Reports

A physician rendering medical treatment and services must submit treatment plans to the carrier in a format prescribed by the Division.

The **Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form- DFS-F5-DWC-25 (DWC-25 Form)** is the document the Division has adopted for physicians to use to request authorization for treatment and to report the medical status of an injured employee. The DWC-25 is also used to document the physician's independent or consultative opinion related to an injured employee's disability, permanent impairment or need for continuing medical treatment addressed in an Independent Medical Examination (IME) Report to the carrier.

Communicating Injured Employee's Medical Status

Chapter 440, F.S., requires the prompt delivery of benefits to the injured employee and reasonable access to medical information relevant to an occupational injury or illness for which compensation is sought. To ensure this intent is accomplished, a physician is required by s. 440.13(4), F.S., to complete the DWC-25 Form to communicate to the carrier an injured employee's medical treatment plan and status. A physician is also required to make such medical information available to all affected parties to facilitate the self-executing features of the Workers' Compensation Law. **Affected parties** include the employer, the carrier, a qualified rehabilitation provider, or the attorney for the employer or carrier.

The communication of the injured employee's medical condition and disability status also includes addressing the injured employee's Maximum Medical Improvement (MMI) date and assigning a Permanent Impairment Rating (PI rating).

Pursuant to s. 440.02(10), F.S., the MMI date is the date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

A permanent impairment is defined in s. 440.02(22), F.S., as any anatomical or functional abnormality or loss determined as a percentage of the body as a whole, existing after the MMI date, which results from the injury. The determination of a MMI date, any permanent impairment or the assignment of a PI rating can only be determined by a physician, pursuant to s. 440.15(3)(b), F.S.

A provider's failure to communicate to the carrier the injured employee's medical condition and disability status in a timely manner may result in the delay of benefits to which the injured employee is entitled. Failure to provide this information may also result in the delay or non-payment of reimbursement for services rendered.

Determination of Permanent Impairment Rating (PI Rating)

Only a Florida-licensed physician can determine whether an injured employee has a permanent impairment and the extent of the permanent impairment resulting from a compensable injury. Moreover, s. 440.13(15)(3)(b), F.S., states that a physician must use a uniform permanent impairment rating guide adopted by the Three Member Panel, to determine, as appropriate, the existence or the extent to which a permanent impairment exists based on the nature of the injury.

The Three Member Panel adopted the **Florida Impairment Rating Guide (FIRG)**, 1993, 1996 Editions, for use **for dates of accident on and after June 21, 1993**. Accordingly, a physician is required to certify the MMI date and PI rating in writing, on the DWC-25 Form, to the carrier and injured employee. The PI rating is calculated to the body as a whole, based on the applicable FIRG in affect on the date of accident when:

- The injured employee has been certified as having reached MMI or is within 6 weeks of receiving 104 weeks of temporary total disability benefits, whichever occurs earlier.

For dates of accidents prior to June 21, 1993, PI ratings are determined by the criteria established in the following impairment guide publications for the dates of accidents indicated:

- The **American Medical Association Guides to the Evaluation of Permanent Impairment**, copyright 1971, 1977, 1988, **for dates of accidents on August 1, 1979 through July 1, 1990;**
- The **Minnesota Department of Labor and Industry Impairment by the American Medical Association, for dates of accidents from July 2, 1990 to June 20, 1993**.

Release of Medical Records and Information

The release of medical records and information does not require the written authorization of the injured employee. Pursuant to s. 440.13(4)(c), F.S., an employee who reports an injury or illness alleged to be work-related, waives any physician-patient privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Therefore, a provider must release the injured employee's medical records or discuss the medical status of the injured employee upon request from an affected party, when such discussions or records are restricted to the workplace injury.

A provider's failure to release medical records or information upon a reasonable request or to release full and truthful medical reports of all his or her findings shall constitute a violation of Chapter 440, F.S., subject to penalties imposed by the Division.

Charges for Copies of Medical Records and Reports A provider may charge an injured employee or his or her attorney to furnish copies of office notes, records and charts as follows:

- Fifty cents ($.50) per page for copying records.
- Provider's actual cost for copying X-rays, microfilm or other non-paper records.

A provider may charge the carrier the industry-accepted copying charges for copies of notes, records and charts. A provider **may not** charge for medical records and information requested by the Division.

Standards of Care The standards of care guidelines discussed in s. 440.13(15), F.S., must be adhered to by physicians and recognized practitioners when rendering treatment and services to injured employees. **Physicians and recognized practitioners must consider these standards of care when rendering or prescribing medical treatment:**

- Abnormal anatomical findings alone, in the absence of objective relevant medical findings, shall not be an indicator of injury or illness, a justification for the provision of remedial medical care or the assignment of restrictions, or a foundation for limitations.
- At all times during evaluation and treatment, the provider shall act on the premise that returning to work is an integral part of the treatment plan. The goal of removing all restrictions and limitations as early as medically appropriate shall be part of the treatment plan on a continuous basis. The assignment of restrictions and limitations shall be reviewed with each patient exam and upon receipt of new information, such as progress reports from physical therapists and other providers. Consideration shall be given to upgrading or removing the restrictions and limitations with each patient exam, based upon the presence or absence of objective relevant medical findings.
- Reasonable necessary medical care of injured employees shall in all situations:
- Use a high-intensity, short-duration treatment approach that focuses on early activation and restoration of function whenever possible.
- Include reassessment every 30 days of the treatment plans, regimes, therapies, prescriptions, and functional limitations or restrictions prescribed by the provider.
- Focus on treatment of the individual employee's specific clinical dysfunction or status and shall not be based upon nondescript diagnostic labels.
- Be inherently scientifically logical, and the evaluation or treatment procedure must match the documented physiologic and clinical problem. Treatment shall match the type, intensity, and duration of service required by the problem identified.

Failure to comply with the preceding standards is a violation of Chapter 440, F.S., subject to penalties imposed by the Division.

Complete Chapter 2 Review Questions Cancel

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Chapter 3 - Administrative Policies for Implementing the Florida Workers' Compensation System

The Division is statutorily responsible for administering Chapter 440, F.S., in a manner to facilitate the self-execution of the system and the process of ensuring the prompt and cost-effective delivery of benefits. To fulfill this responsibility, the Division has developed and adopted administrative rules, which are incorporated in the Florida Administrative Code.

This Chapter of the EMA Tutorial will discuss in detail the administrative rules adopted by the Division related to:

- The proper completion and submission of medical bills, medical forms, and reports related to medical services rendered and the injured employee's medical status.
- The reimbursement policies and the reimbursement methodology for covered services.
- The process for the resolution of reimbursement disputes between the provider and carrier.

A provider's familiarity and compliance with the following administrative policies will ensure injured employees receive medically necessary treatment and services in a timely manner and providers receive prompt reimbursement for authorized services.

Health Care Provider Reimbursement Manual

The Florida Workers' Compensation Health Care Provider Reimbursement Manual (HCP Reimbursement Manual), Rule Chapter 69L-7.020, F.A.C., provides reimbursement guidelines, codes and maximum reimbursement allowances for physicians and recognized practitioners rendering medically necessary treatment and services to Florida's injured employees. The HCP Reimbursement Manual also contains reimbursement policies and payment methodologies for pharmacists and medical suppliers.

The general reimbursement guidelines establish basic utilization controls for medically necessary treatment and services rendered by certified providers, which require prior authorization to treat, and effective communication between providers and carriers as conditions for reimbursement.

The more specific guidelines are related to the use of procedure codes and descriptors to report and bill services rendered. These guidelines also address the application of established reimbursement methodology for determining appropriate maximum reimbursement allowances for billed services. The established reimbursement methodology guidelines are:

- The maximum reimbursement allowance (MRA) for the billed CPT® code in the geographic location for the place of service in which treatment is rendered.
- Reimbursement By Report (BR) applies when a specific MRA has not been established for a billed service.

Reimbursement Manual for Hospitals

The Florida Workers' Compensation Reimbursement Manual for Hospitals (HOSP Manual), Rule Chapter 69L-7.501, F.A.C., establishes reimbursement guidelines for hospitals licensed under Chapter 395, F.S. These guidelines are specific to inpatient and outpatient care, surgical and non-surgical services as well as emergency and other hospital services.

Only medically necessary **hospital services** ordered by a physician and authorized by the carrier (except for emergency treatment) are reimbursable.

Physician and other professional services rendered in a hospital are reported separately by the treating physician or recognized practitioner and are reimbursed in accordance with the HCP Reimbursement Manual.

Reimbursement Manual for Ambulatory Surgical Centers

Pursuant to the Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers (ASC Manual), Rule Chapter 69L-7.100, F.A.C., reimbursement for ASC services is based on the MRA on the list of surgical procedure codes contained in the ASC Manual. If a procedure code for the surgery performed is not on the list, reimbursement is based on a percentage of billed charges. Facility services include all services and procedures furnished in connection with covered surgical procedures performed in an ASC, including, but are not limited to, the use of the facility, surgical supplies and equipment and nursing services.

Physician services rendered in an ASC are reported separately by the treating physician or recognized practitioner and are reimbursed in accordance with the HCP Reimbursement Manual.

Medical Services Billing, Reporting and Filing Rule (Billing Rule)

The Florida Worker's Compensation Medical Services and Utilization Rule (Billing Rule), Rule Chapter 69L-7.710 series, F.A.C., instructs providers on how to properly complete medical billing forms. The Billing Rule specifically addresses a provider's responsibility for using correct billing forms based on provider type and for using **proper procedure codes** or Workers' Compensation Unique codes to report, per line item, the frequency, level, intensity and duration of services rendered.

The Billing Rule also includes form completion instructions by provider type(s):

- The DFS-F5-DWC-9 (CMS 1500 Health Insurance Claim Form) for services rendered by a physician, or a recognized practitioner.
- The DFS F5 DWC 10 Statement of Charges for Drugs and Medical Supplies for pharmacy and home medical equipment (DME) services.
- The DFS-F5-DWC-11 (ADA Dental Claim Form) for dental services.
- The DFS-F5-DWC-90 (CMS 1450 UB-04 Uniform Bill) for inpatient and outpatient hospital services, for ASC services, for nursing home services, and for home health services.

At the time of authorization for medical service(s) a carrier must notify the provider, in writing, of additional form completion requirements or supporting documentation that are necessary for reimbursement determinations.

Utilization and Reimbursement Dispute Rule (Dispute Rule)

The Utilization and Reimbursement Dispute Rule (Dispute Rule), Rule Chapter 69L-31, F.A.C., covers the process that a provider must follow to contest a carrier's reimbursement for services rendered to an injured employee. Chapter 6 of this tutorial addresses in detail the process for filing a Petition for Reimbursement Dispute Resolution including how to complete a petition, how to provide copies to affected parties, and the statutory time-frames for completing each step.

Complete Chapter 3 Review Questions Cancel

Chapter 4 - Billing and Reporting Medical Services

Physicians, recognized practitioners, and facility providers shall use the following publications for billing and reporting medical procedures and services provided to injured employees for reimbursement purposes:

- CPT® Current Procedural Terminology Professional Edition, Copyright, American Medical Association.
- CPT® Assistant
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Expert for Physicians Volumes 1 and 2.
  NOTE: ICD-9 shall be used prior to the federal implementation date for the use of the ICD-10.
- International Classification of Diseases, 10th Revision, Clinical Modification (The Complete Official Draft Codebook ICD-10-CM).
  NOTE: ICD-10-CM can be used on or after the federal implementation date. **ICD-9 AND ICD-10 CODES CANNOT BE USED TOGETHER**.
- CDT-Dental Procedure Codes. Copyright, American Dental Association.
- The American Medical Association Healthcare Common Procedure Coding System, Medicare's National Level II Codes (HCPCS).

In addition to the use of procedure codes and modifiers contained in the above-referenced publications, a provider shall also use codes designated in the reimbursement manuals as workers' compensation unique codes and modifiers.

Time Frames for Filing Medical Bills and Reports

There are no statutory time frames for filing medical bills to request reimbursement for services rendered to an injured employee. However, timely filing of medical bills and forms is an integral part of the self-executing features of the Florida Workers' Compensation System to facilitate:

- determination of whether the injured employee's entitlement of benefits;
- prompt delivery of benefits to an injured employee;
- prompt receipt of reimbursement; and
- efficient determination of whether the billed services are covered.

DWC-25 Forms Submission Time Frames

Physicians are required to submit the DWC-25 Form in accordance with the time frames established in the Billing Rule to request authorization for services, and to report the injured employee's medical status.

The DWC-25 Form is submitted to the carrier as discussed below depending on whether the physician completing the form is a treating physician or a non-treating physician.

Treating physicians:

- The **initial DWC-25 Form** must be **submitted within three (3) business days of the initial encounter**. This initial form is to communicate the recommended treatment plan, or to request authorization for subsequent follow-up care, and to report the medical status.
- **Subsequent DWC-25 Forms** must be submitted by the close of the business day following the date of the actionable event or at a maximum of 30 days from the submission of the prior DWC-25. The **interim DWC-25 Form** also reports the medical status of the injured employee, updates medical treatment recommendations and requests authorization for subsequent follow-up care.
- The **final DWC-25 Form** addressing the injured employee's MMI date and PI rating must be **submitted to the carrier by the close of the business day following the date of service.**

Non-treating physicians:

- The **DWC-25** Form documenting the physician's opinion or finding(s) resulting from an **Independent Medical Examination (IME)** must be submitted to the carrier **with the IME report within ten (10) business days following the date of service.**
- The **DWC-25 Form** addressing the injured employee's **MMI date and PI rating** must be **submitted to the carrier by the close of the business day following the date of service.**

Complete Chapter 4 Review Questions Cancel

Chapter 5 - Reimbursement Guidelines and Methodology

Covered medical treatment and services are reimbursed in accordance with the applicable provider reimbursement manual, unless the provider has entered into a contract with the carrier.

Pursuant to s. 440.13(12)(a), F.S., reimbursement allowances promulgated in the provider reimbursement manuals are set by the Three Member Panel.

Physician and Recognized Practitioner Reimbursement

Physician Reimbursement

Physicians and recognized practitioners are paid the MRA listed for the billed CPT® code based on the geographic location for services rendered in a facility or non-facility. The MRA is based on the following:

- 110 percent of the Medicare reimbursement allowance for non-surgical services;
- 140 percent of the Medicare reimbursement allowance for surgical services.

Certain CPT® codes are designated **By Report (BR)** for reimbursement based on the carrier's evaluation of the documentation submitted to justify the reimbursement level. The documentation, as required by the carrier, is submitted as a report and includes:

- A complete description of the services or procedures;
- Documentation of medical necessity based on pertinent clinical data; and
- Prevailing charges, fees, relative values and reimbursement for similar procedures or cost of the services or supplies.

Recognized Practitioner Reimbursement

Recognized Practitioners are reimbursed a percentage of the listed MRA according to licensure type and scope of practice as indicated:

- Physician assistants and advanced registered nurse practitioners are reimbursed 85 percent of the physician's MRA for direct billable surgical and non-surgical services.
- Physical and occupational therapists, audiologists, speech pathologists, and psychologists are reimbursed the listed MRA for the billed service.
- Licensed clinical social workers are reimbursed 75 percent of the MRA listed for the billed service.
- Dietitians, nutritionists, and nutrition counselors are reimbursed 85 percent of the MRA listed for the billed service.

Dispensing Practitioner Reimbursement

Dispensing physicians and recognized practitioners shall be reimbursed for non-prescription medication and medical supplies as follows:

- Non-Prescription Medication and Medical Supplies are reimbursed at 120 percent of Invoice cost for dispensing non-prescription medication and non-incidental supplies.
- Prescription Drugs are reimbursed either the:
  - Average Wholesale Price (AWP) + $4.18 dispensing fee; or
  - Contracted rate agreement entered into directly by the dispensing physician and WC insurer for a lower rate.
- Repackaged Prescription Drugs are reimbursed either the:
  - Statutory Formulary of 112.5 percent of the original manufacturer's average wholesale price (AWP), plus $8.00 for the dispensing fee; or
  - Contracted rate agreement entered into directly by the dispensing physician and WC insurer for a lower rate.

Dispensing Pharmacy Reimbursement

Dispensing Pharmacies shall be reimbursed as follows:

- Over-the-Counter Medications are reimbursed at the pharmacy's usual and customary charges.
- Medical Supplies and non-prescription medication are reimbursed at 120 percent of invoice cost.
- Prescription Drugs are reimbursed the average wholesale price (AWP) + $4.18 dispensing fee.
- Repackaged Prescription Drugs are reimbursed either the:
  - Statutory Formulary of 112.5 percent of the original manufacturer's average wholesale price (AWP), plus $8.00 for the dispensing fee; or
  - Contracted rate agreement entered into directly by the dispensing physician and WC insurer for a lower rate.

Facility Reimbursement

Reimbursement for facility services are based on a percentage of billed charges or a listed MRA or for some inpatient hospital services, a per-diem rate. Reimbursement for other facility types for which a reimbursement schedule has not been adopted, reimbursement is based on a reimbursement contract between the provider and WC insurer.

Hospital Reimbursement

Hospital reimbursement is based on the type of admission **(inpatient or outpatient)** or the type of care rendered **(surgical or non-surgical).**

- **Inpatient** hospital care is reimbursed on a **per diem** or **"stop-loss"** rate. The per diem rate for a surgical admission is approximately $3,000.00 and the per diem for a non-surgical admission is approximately $1,000.00. When the total billed charges, less implant charges carve-out, exceed a **"stop-loss" of $59,891.34**, reimbursement is based on 75 percent of total billed charges. **Outpatient hospital care** is reimbursed 75 percent of usual and customary charges, except for scheduled surgeries and non-emergency radiology and clinical laboratory services.

- **Scheduled outpatient surgery** is reimbursed 60 percent of usual and customary charges, including clinical lab and X-rays performed within three (3) days before the surgery date.

- **Non-emergency radiology and clinical laboratory services** are reimbursed the MRA listed for the billed procedure in accordance with the HCP Reimbursement Manual.

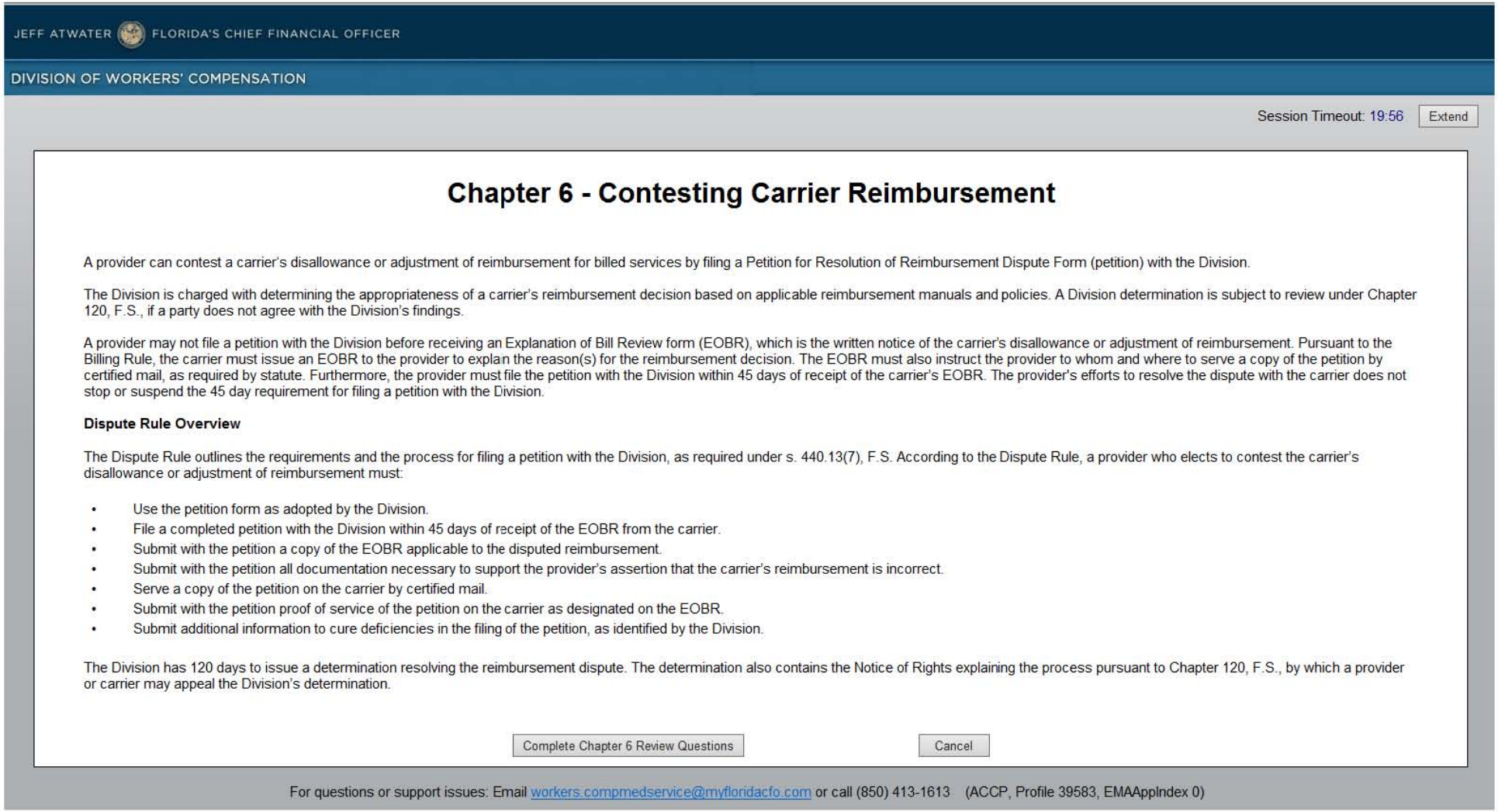
Ambulatory Surgical Center Reimbursement

Ambulatory Surgical Center reimbursement allowances include reimbursement for facility service charges at a percentage of total billed charges, or the listed MRA for billed services.

Other facilities

There is no specific reimbursement schedule adopted for home medical equipment companies **(HME)**, home health care agencies **(Home Health)**; nursing homes **(NH)**; public health clinics **(HC)**; and assisted living facilities **(ALF)**. Reimbursement is based on a written contract mutually agreed upon at the time of authorization of the medical services prescribed or ordered by a physician and documented in the reporting and billing of services rendered.

Complete Chapter 5 Review Questions Cancel



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