

SELF-ASSESSMENT

1997 HCP FFSRM

RULE PROMULGATION

1. The name of the new manual is:
 a. The Workers' Compensation Fee Schedule
 b. The RBRVS Manual
 c. 1997 Florida Workers' Compensation Reimbursement Schedule
 d. 1997 Florida Workers' Compensation Health Care Provider Fee-For-Service Reimbursement Manual (HCPFFSRM)
 e. Rule 38F-7.020, F.A.C.
2. The effective date of the implementation of Rule 38F-7.020, F.A.C., the HCPFFSRM, is _____.
3. Amendments filed to change the rule are effective immediately upon filing.
 a. True
 b. False

DEFINITIONS

4. Which edition of the Physicians' Current Procedural Terminology (CPT) is incorporated by Rule 38F-7.020, F.A.C.?
 a. 1995 CPT
 b. 1996 CPT
 c. 1997 CPT

GENERAL BILLING AND REIMBURSEMENT REQUIREMENTS

5. It is the responsibility of health care providers to submit a complete report of the patient/injured employee's symptoms, findings and plan of care to the carrier. This should be accomplished
 a. Within seven (7) working days from the date of the initial service.
 b. Within ten (10) working days from the date of the initial service.
 c. Within fourteen (14) working days from the date of the initial service.
 d. Within fifteen (15) working days from the date of the initial service.
6. Modifiers, when added to procedure codes, are specific number combinations which convey information regarding the circumstances under which the services were provided. Florida's Workers' Compensation program advocates the use of the five-digit modifier series, listed in the CPT, only when billing
 a. Neurological testing.
 b. Radiology procedures.
 c. Surgery.
 d. Anesthesia.

Answers: 1. d. 2. 9/1/97 3. b. 4. b. 5. d. 6. d.

7. Out-of-state providers who do not receive prior authorization from carriers may be reimbursed 100% of their usual and customary charges.
- a. True
 - b. False

PSYCHIATRIC AND PSYCHOLOGICAL SERVICES

8. Psychiatric and psychological services may be billed by an authorized
- a. Medical doctor licensed under Chapter 458, F.S.
 - b. Osteopathic physician licensed under Chapter 459, F.S.
 - c. Psychologist licensed under Chapter 490, F.S.
 - d. Other qualified mental health professionals licensed in Florida and providing services consistent with their defined scope of practice.
 - e. a, b, c.
 - f. a, b, c, and d.
9. Reimbursement for psychological and neuropsychological testing includes the
- a. Administration of the test
 - b. Scoring of the test
 - c. Interpretation of the results of the test.
 - d. Preparation of a written report.
 - e. a only.
 - f. a, b, c.
 - g. a, b, c, and d.
10. Reimbursement for psychological testing, when using procedure code 96100 (for example: billing for a Rorschach or a MMPI), is made on
- a. A per test basis.
 - b. A per hour basis.

SOFT TISSUE INJURY CARE

11. For the Florida Workers' Compensation program initial treatment for a soft tissue injury shall be billed by the physician using
- a. A procedure code from the casting and strapping procedure codes 29000-29799.
 - b. An evaluation and management service procedure code.
 - c. Procedure code 99070 for supplies and materials, such as stockinette, plaster, fiberglass and ace bandages to strap or cast the soft tissue injury.
 - d. Only b and c.
12. Reimbursement for a replacement cast or strapping includes reimbursement for the service, supplies and materials and the removal of the cast or strapping.
- a. True
 - b. False

Answers: 7. b. 8.f. 9. g. 10. b. 11. d. 12. a

13. When subsequent and significant, identifiable, medical services are provided for soft tissue injuries, physicians may be paid for their charges for evaluation and management services in addition to the replacement casting and strapping procedures.
- a. True
 b. False

EVALUATION AND MANAGEMENT

14. There are four CPT subcategories of consultations: office, initial inpatient, follow-up inpatient and confirmatory.
- a. True
 b. False
15. When a consultation is performed and billed, reimbursement will be made at the level which the documentation supports and does not include reimbursement for a report.
- a. True
 b. False
16. A health care provider may bill and be reimbursed for a telephone conference for medical management lasting 5-10 minutes.
- a. True
 b. False

MMI/PI/IME

17. Should the provider and carrier reach an agreement on the amount to be reimbursed for an IME before the service is rendered?
- a. Yes
 b. No

INJECTIONS

18. The correct procedure code(s) to bill for an intramuscular (IM) antibiotic injection at a doctor's office when there is no evaluation and management (E/M) services performed is_____.
- a. J-Code + 90782
 b. J-Code + 90788
 c. J-Code + E/M code
 d. J-3490

Answers: 13. a. 14. a. 15. b. 16. b. 17. b. 18. b.

DENTAL, APPENDIX D - DENTAL CROSSWALK

19. Oral and maxillofacial surgery is billed on LES Form _____.
_____a. LES Form DWC-9 or 11
_____b. LES Form DWC-11
_____c. LES Form DWC-9
_____d. LES Form DWC-10
20. Depending on documentation, oral and maxillofacial surgery code D-7980 equates to CPT code(s) _____.
_____a. 42330
_____b. 42335
_____c. 42340
_____d. All of the above

PATHOLOGY/RADIOLOGY APPENDICES B, C & E)

21. If the health care provider fails to add -26 to a radiological procedure code provided in a hospital, ASC or similar facility, reimbursement shall only be made for the professional component.
_____a. True
_____b. False
22. Total or “global” procedure is a term that applies to diagnostic procedures that have two components, a technical component, and a professional component. When both components are provided by the physician, charges are billed using the 5-digit CPT code without modifiers.
_____a. True
_____b. False

Match the correct MRA responses using the tables in Appendix E (Services provided as Fee-For-Service).

Column A	Column B
_____23. alternate surgeon provides post-operative follow-up for 11043	a) \$ 17
_____24. primary procedure 21480	b) \$ 19
_____25. MRA for 22114-51	c) \$ 23
_____26. MRA for 74320	d) \$ 24
_____27. MRA for 94620-26	e) BR
_____28. MRAS for 89399	f) \$ 25
_____29. MRA for 89329 (technical component)	g) \$ 27
_____30. MRA for chiropractic spinal adjustment	h) \$ 33.50
_____31. MRA for 21480-50	i) \$ 17.25
	j) \$ 41
	k) \$ 42
	l) \$ 80
	m) \$ 67
	n) \$133
	o) \$220
	p) \$440
	q) \$880

Answers: 19. c. 20. d. 21. a. 22. a.
23. \$19 24. \$67 25. \$440 26. \$133 27. \$42 28. BR 29. \$41 30. \$25 31. \$33.50

PHYSICAL MEDICINE

32. The appropriate procedure code for a physical therapist to sue for billing an initial assessment is:
- a. 97700
 - b. Q0103
 - c. Q0109
 - d. the appropriate E/M code
33. The proper procedure for billing additional time for procedure code 97530 is:
- a. Billing is limited to one procedure code (unit of service) for 97530 per visit.
 - b. Bill an additional unit of procedure code 97530.
 - c. Bill procedure code 97531.
 - d. None of the above.

SURGERY

Situation: Big Al, a physician assistant, received authorization from AdLib Insurance Co. to assist at surgery in an urgent situation. The surgeon, Dr. Cuther, billed \$5000 and was reimbursed \$2000 for her services. Big Al billed \$1600 for his services.

34. How much should the carrier reimburse Big Al?
- a. \$1000 (50% of surgeon's reimbursement)
 - b. \$500 (25% of surgeon's reimbursement)
 - c. \$375 (18.75% of the surgeon's reimbursement)
 - d. \$400 (20% of the surgeon's reimbursement)

Situation: Dr. Cuther and Dr. Knifehim were co-surgeons performing procedure code 63015 which they each billed using the procedure code with Modifier -62 added. Dr. Cuther billed \$2000 and Dr. Knifehim billed \$1800. Using Appendix #, page 204, and key on pages 73-74 of the blue pages, determine the following:

35. Can they bill and get paid as co-surgeons for procedure 63015?
- a. Yes
 - b. No
36. Which is the correct reimbursement?
- a. Dr. Cuther as the primary surgeon receives the MRA, \$2660; Dr. Knifehim receives \$665 as the assistant surgeon.
 - b. Dr. Cuther and Dr. Knifehim each get \$2660 as co-surgeons.
 - c. Dr. Cuther and Dr. Knifehim each get \$1662.50.

ANESTHESIA

Situation: Dr. Gasum provided anesthesia for an insertion of a cardioverter, procedure code 00534 (p. 52), on a seventy-five year old Supreme Court Judge. Because of severe systemic disease, alternative anesthesia including controlled hypotension was employed.

Answers: 32. b. 33. b. 34. c. 35. a. 36. c.

37. The correct billing code(s) is (are):
- a. Procedure code 00534-22
 - b. Procedure code 00534-P3 and 99100
 - c. Procedure code 00534-23
 - d. Procedure code 00534-P3, 99100 and 99135
38. If the surgery lasted one hour and 30 minutes, which is the correct entry for Element 24G of the DWC-9?
- a. 1:30
 - b. 130
 - c. 9 (units)
 - d. 90
39. Assuming the services were authorized for a workers' compensation injury, determine the maximum anesthesia reimbursement allowance (ARA) based on the 1997 RM.
- Help: [Procedure Code 00534 has 7 Basic Value Units (page 52). Pages 46 and 47 give values for exceptional circumstances.]
- Compute the total units, then use Table 1 on page 58 to determine the ARA, which is the maximum?
- a. \$191.38
 - b. \$437.44
 - c. \$683.50
 - d. \$656.16

Answers: 37. d. 38. d. 39. c