

State of Michigan
Workers' Disability Compensation

**Health Care
Services Manual**
(Fee Schedule)

Effective: May 11, 2000



*Serving Michigan...
Serving You*

Department of
Consumer & Industry Services

State of Michigan

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Health Care Services Manual

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CHAPTER 1

Overview and Guidelines

Introduction

The Health Care Services Policy Manual contains information regarding health services provided to treat an injury or illness causally related to employment for Michigan workers. The billing and payment information contained in this manual is effective for dates of service occurring on or after May 11, 2000.

The manual is organized as follows:

General Information (Chapters 1-5) outlines the general policies and procedures applicable to all providers and payers.

CPT Information (Chapters 6-13) contains a chapter for each category of medical service. The policies, procedures and the maximum allowable payment (MAP) are listed in each category of service.

Ancillary Services (Chapter 14) contains coding and payment information for services described with coding from Medicare's National Level II Code book.

Hospital Services (Chapter 15) contains information regarding payment for facility services and the hospital's maximum payment ratios.

Bureau Information (Chapter 16) contains examples of forms, Bureau contact numbers.

The Health Care Services Manual was designed to be as user friendly as possible. For suggestions for further improvements or to report any possible errors, please contact:

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Copyright Notice

Procedure codes and descriptors found in this manual are from the 1996 edition of Current Procedural Terminology (CPT) published by the American Medical Association (AMA). All

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rights reserved. Abbreviated descriptors are noted in this manual. **For a complete description of the procedure codes, refer to *Current Procedural Terminology (CPT)*.**

No fee schedules, relative value units (RVU's) or conversion factors are included in the CPT. The AMA assumes no responsibility for the consequences attributed to or related to any use or interpretation of any information contained or not contained in this product.

The AMA does not directly or indirectly practice medicine nor dispense medical services. The AMA assumes no liability for the data contained herein.

Providers Covered by the Rules

All providers of health care services must be licensed, registered or certified as defined in the Michigan Public Health Code, Act 368 of 1978, (Articles 1,7,15,19, and Excerpts from Article 5) as amended.

Evaluation and Management services and minor surgical procedures performed by nurse practitioners and physician's assistants are billed with modifiers. Reimbursement is adjusted to 85% of the MAP amount or the practitioner's usual and customary charge, whichever is less. Service level adjustment factors are as follows:

Nurse Practitioner	-AK	0.85
Physician's Assistant	-AU	0.85

Reimbursement for therapeutic mental health services are adjusted according to a service level adjustment factor. Services billed by the following practitioners must be identified by the listed modifiers and will be adjusted to 85% or 64%, depending on the service provider noted by the modifier. No adjustment is necessary for diagnostic testing procedures performed.

Certified Social Worker	-AJ	0.85
Limited License Psychologist	-AL	0.85
Licensed Marriage & Family Therapist	-MF	0.85
Licensed Professional Counselor	-LC	0.85
Limited Licensed Counselor	-CS	0.64
Limited Licensed Marriage & Family Therapist	-ML	0.64

Services Listed in the Manual

The state of Michigan workers' compensation schedule of maximum allowable payments are listed in this manual. Chapters 6-13 contain the policy and procedures unique to that

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category and the services are listed in numeric order according to CPT coding. The manual lists the CPT code, the RVU, the MAP and the follow-up days for surgical procedures. **Except where otherwise noted in this manual, billing instructions listed in "Current Procedural Terminology (CPT)" shall apply.**

Maximum Allowable Payment (MAP) Amounts

The maximum allowable payments in this manual are based upon the Health Care Financing Administration's (HCFA) resource-based relative value scale¹ (RBRVS). RBRVS attempts to ensure the fees are based on the resources used to provide each service described by CPT procedural coding. Relative values are derived based on the work involved in providing each service (practice expense involved including office expenses, and malpractice insurance expense), and applying specific geographical indices, (GPCI), to determine the relative value unit (RVU). Michigan workers' compensation is applying the following GPCI resulting from a meld using 60% of the Detroit area GPCI and 40% of the rest of the state's GPCI.

Work	1.037
Practice Expense	1.036
Malpractice	1.483

The following formula is applied to the information taken from HCFA to determine the RVU for the state of Michigan workers' compensation.

$$(\text{Work RVU's} \times 1.037) + (\text{Practice Expense RVU's} \times 1.036) + (\text{Malpractice RVU's} \times 1.483) = \text{RVU}$$

Most MAP amounts in Chapters 6-13, (except for anesthesia services), are pre-calculated and listed as dollar amounts. The MAP amounts were determined by multiplying the **RVU times the conversion factor** as follows:

- , Surgical services conversion factor is \$54.05
- , Medical services conversion factor is \$42.92
- , Radiology services conversion factor is \$50.51

Determining Payment

1

From the RBRVS Fee Schedule: A Plain English Guide copyright 1996

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The MAP amount's listed in this manual represent the maximum allowable payments that a provider can be paid for rendering services under the state of Michigan Workers' Compensation Act. When a provider's charge is lower than the MAP amount, or if a provider has a contractual agreement with the carrier to accept discounts for lower fees, payment is made at the lower amount.

Workers' Compensation laws are state specific and these rules and fees apply to providers licensed to practice in Michigan. A provider licensed by the state of Michigan billing a carrier for a service must accept the maximum allowable payment and shall not balance bill the worker (Refer to R 418.10105).

"By Report (BR) Services"

When a CPT code does not have an assigned numeric RVU, the procedure will be listed as BR (by report). A provider who submits a claim for a BR service(s) should include all pertinent documentation, including an adequate definition or description of the nature and extent of the service and the time, effort, and equipment necessary to provide the service. A BR procedure is reimbursed at the provider's usual and customary charge or reasonable amount determined by the carrier, whichever is less.

Codes Not Listed in the Manual

Every effort has been made to include all of the CPT codes and the assigned relative value units in this manual. Inclusion of the CPT code in the manual does not guarantee compensability of the service. The carrier is responsible for reviewing the service(s) to determine if the treatment is related to the work injury or illness.

When a procedure code is not listed in the manual but is listed in either CPT or Medicare's National Level II HCPCS for the date of service, the code shall be billed and reimbursed at the provider's usual and customary charge or reasonable amount, whichever is less.

Independent Medical Evaluations (IMEs)

A carrier or employee may request an independent medical evaluation (IME). An independent medical examination must be done by a practitioner other than the treating practitioner. The IME is exempt from the health care services rules for cost containment and payment is determined on a contractual basis.

A carrier may request an examination to determine the medical aspects of the case. This examination would be considered a confirmatory consult. The confirmatory consult is billed with procedure codes 99271-99275 and paid in accord with the fees listed in the

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E/M section of this manual.

Claim Filing and Limitation

A provider should promptly submit their charges to the carrier to expedite claims processing. The carrier is not required to reimburse claims submitted after **one year from the date of service except for:**

- , litigated cases
- , when subrogation has occurred

Do not submit claim forms or requests for reconsideration to the Bureau, as the Bureau does not pay or review bills. See Rule 113 and Rule 901(3).

CHAPTER 2

General Policies

This chapter contains the general information regarding medical services provided to injured workers in the state of Michigan.

Employee Responsibilities

An employee who receives an injury or illness during the course of employment must report the injury to his employer. After the initial 10 days of medical treatment, **the worker may choose to treat with the provider of their choice and must notify the carrier in writing of that choice.** If an employee receives a bill from a health care provider for a covered work injury, the employee should submit the bill to the employer or if known the worker's compensation carrier for payment.

Employer Responsibilities

The Workers' Disability Compensation Act outlines in section 315 that an employer must furnish or cause to be furnished all necessary and reasonable medical, surgical, and hospital services and medicines, other attendance or treatment recognized as legal, for an employee receiving an injury or illness in the course of employment. The employer has the right to direct the employee to a provider of the employer's choice for the first 10 days of care commencing for the injury or illness and should **report the injury to their workers' compensation carrier.**

The insured employer must promptly file the form 100, "Employer's Basic Report of Injury" to the Bureau to report cases when the injury results in 7 or more days of disability, specific loss or death. The insured employer must inform the provider of the name and address of its insurer or the designated agent of the insurer to whom the health care bills should be sent. If the insured employer receives a bill, the employer shall promptly send the provider's bill and documentation to the carrier.

Provider Responsibilities

A provider shall promptly bill the carrier on the proper claim form and attach any documentation required by the Health Care Services Rules. When a provider bills the carrier and receives **no response in 30 days, the provider should send a second copy of the bill to the carrier and add a 3% late fee.**

The provider may file for an "Application for Mediation and Hearing" (104B) for

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unresolved claims (See Part 13 of the Rules and Chapter 4 p. 4.5 of this manual) when:

- , The provider has sent 2 bills to the carrier and waited a total of 60 days for a case that has not been disputed.
- , Payment was not made in accord with the maximum payments established by the Health Care Services Rules, or the carrier has disputed utilization of the overall services. If the issue(s) are not resolved through the reconsideration process, the provider may file a 104B.
- , When the worker has contested a carrier dispute and the case becomes contested (worker files 104A for a Bureau hearing). **Provider should file a 104B to be added as an intervening party to the carrier/worker dispute.**

Note: If the worker has not "contested" the carrier denial, then the worker or his health insurance is responsible for services disputed as not work-related.

Note: When the case is in dispute, the provider may not turn the worker into "collections."

Carrier Responsibilities

When the carrier receives notice of an injury or illness, the carrier establishes a case record and determines compensability of the case. When the carrier receives a bill from the provider and does not have an injury report on file from the employer, the carrier should follow-up with the employer. **The carrier is required to pay the medical services within 30 days of receipt of a provider's properly submitted bill or must pay the provider a 3% late fee applied to the MAP.**

A carrier shall notify the provider of the carrier's decision to adjust or reject a medical provider's bill on a form entitled "**The Carrier's Explanation of Benefits.**" A copy must be sent to the injured worker. The format for this form is determined by the Health Care Services Division of the Bureau. Changes may not be made to the form by the carrier without Bureau approval. A copy of the form is located this manual in Bureau Information.

The State of Michigan Workers' Disability Compensation Act does not mandate managed care or prior authorization for reimbursement of medical services. The carrier is required to review the medical services provided to ensure that the services are reasonable and related to the work injury or illness (refer to Part I, Rule 101, Scope of the Rules).

A carrier must have its professional **utilization review program certified** by the Bureau by

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completing and submitting the form "Application for Certification of Professional Review." A copy of the form is located in this manual in Chapter 16, Forms. The carrier must submit the application and include:

- , Methodology for review
- , Licensure documentation for review staff
- , List of peer reviewers

Certification is generally granted for a period of 3 years. When all of the criteria are not fully satisfied, the Bureau may issue a conditional certification for a period of one year when the carrier agrees to take corrective action. At least 6 months prior to the expiration of the certification date, the carrier must send in an application for renewal.

A carrier is also required to submit an "**Annual Medical Payment**" report to the Bureau documenting the number of medical only cases, the number of wage loss cases and the total dollars spent for health care for those cases. A copy of the form and instructions for completion are located in this manual in Chapter 16, Forms.

Required Documentation

Providers are required to submit documentation for the following: (See Rule 901)

- , The initial visit
- , A progress report if still treating after 60 days
- , Evaluation for physical treatment (PT, OT, CMT, OMT)
- , A progress report every 30 days for physical treatment
- , An operative report or office note (if done in the office) for a surgical procedure
- , A consultation
- , A written report is required whenever the professional component of an x-ray is billed
- , The anesthesia record for anesthesia services
- , A functional capacity or work evaluation
- , When billing a BR (By Report) service, a description of the service is required
- , Whenever a modifier is used to describe unusual circumstances
- , Whenever the procedure code descriptors includes a written report

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Medical Records. The provider's medical record is the basis for determining necessity and for substantiating the service(s) rendered; therefore, the record may be requested by the carrier. Medical records must be legible and include the information pertaining to:

1. The patient's history and physical examination appropriate to the level of service indicated by the presenting injury or illness;
2. Operative reports, test results and consultation reports;
3. Progress, clinical or office notes that reflect subjective complaints of the patient, objective findings of the practitioner, assessment of the problem(s), and plan(s) or recommendation(s).
4. Disability, work restrictions, and length of time, if applicable.

Copies of Records and Reports

A carrier or a carrier's agent, a worker or a worker's agent may request additional case records other than those required by the Rules (See Rule 113 and Rule 114). Providers are entitled to charge for the cost of copying the records. **Only those records for a specific date of injury are covered under the Health Care Services Rules.** Those records are reimbursed at 25¢ per page plus the actual cost of mailing. In addition, an administration charge shall be paid for the staff's time to retrieve and copy the record and is paid as follows:

0-30 minutes	\$3.50
31-60 minutes	\$7.00
each additional 30-minute increment	\$3.50

The copying and handling charge applies to all reports and records, **except** the original copy required under the provision of Rule 113 and all other reports required by the Rules. The copying charges are paid by the party requesting the records.

For records other than those applying to the specific date of injury (case record) the provider may bill their usual and customary charge.

CHAPTER 3

Billing Policy

This chapter contains policies and procedures for providers submitting claims and for payers reviewing and processing those claims. Specific instructions for completing claim forms are found in Chapter 5. Additional billing information is contained in Chapters 6-13 of this document. Each CPT section contains billing information specific to the category of services listed in that section.

Billing Information

Providers must submit charges to the carriers on the appropriate health insurance claim form. Documentation required by the rules must be legible. A carrier must pay only licensed providers. When a provider treats an injured worker, the claim is sent to the workers' compensation carrier. The provider shall be paid the maximum allowable payment (MAP) allowed by the Health Care Services Rules for services to treat a covered work injury or illness.

The following claim forms are adopted by the Health Care Services Rules for billing medical services:

- , Use the HCFA-1500 claim form for practitioner billing
- , Use the UB-92 claim form to bill for facility services
- , Use either the universal pharmacy claim form or an invoice to bill outpatient pharmacy services
- , Use the standard American Dental claim form for dental services

Note: A hospital occupational or industrial clinic is considered a practitioner service. In addition, home health services are considered practitioner services.

A provider may not bill for missed appointments unless the appointment was made by the carrier or employer (e.g., **IME or confirmatory consult**). Unless the employer cancels 72 hours in advance, the provider may bill the carrier for the missed appointment using procedure 99199 and payment shall be "by report" (BR).

Balance Billing

According to Michigan law, a provider may not bill the employee for any amount of the charge for health care services provided for the treatment of a covered injury or illness.

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A provider may not balance bill (refer to Rule 105):

- , when the amount is disputed by utilization review
- , when that amount exceeds the maximum allowable payment

When there are balances due to the utilization review, the provider may send a request for **reconsideration to the carrier**, and if unresolved, file a request for mediation (unless the MAP was paid by the carrier).

Procedure Codes

Procedure codes from *Physician's Current Procedural Terminology (CPT)* and *Medicare's National Level Codes (HCPCS)* are used to report medical services. CPT coding is used primarily for services, and HCPCS codes are used to report supplies and durable medical equipment as well as ancillary services such as dental services, hearing and vision services. The CPT procedure codes and MAP amounts are listed in Chapters 6-13. Services not listed in the schedule will be considered as "by report" (BR).

Injectable Pharmaceuticals and Supplies Dispensed in the Practitioner's Office

When an injectable drug is administered along with an evaluation and management service, the drug is billed with procedure code 99070, and identified with the national drug code, (NDC) obtained from Red Book. An administration fee is not paid in conjunction with an office visit. The drug is reimbursed at average wholesale price (AWP).

When a physician dispenses a prescription drug from his office, the drug is reimbursed at AWP plus a \$4 dispense fee. The dispense fee cannot be paid more often than every 10 days for **each** prescription drug. A dispense fee is not paid when over-the-counter (OTC) medications are dispensed.

Supplies dispensed from the practitioner's office are billed with code 99070, or the appropriate HCPCS code, and a report describing the service must be attached to the bill. Supplies are reimbursed at AWP + not more than 50%.

Pharmacy Services

Outpatient pharmacies and providers dispensing prescription drugs or medical supplies must have oral or written confirmation from the carrier that the services are for a covered work injury along with instructions on where the bill is to be sent. Until such direction is given by the carrier, those providers are not bound by the Health Care Services Rules.

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An outpatient or mail-order pharmacy must submit charges for prescription medications on either a universal pharmacy claim form or an invoice statement.

Charges for prescription drugs dispensed from the doctor's office or a health care organization shall be submitted on a HCFA 1500.

The following apply to pharmacy services:

- , The generic drug must be dispensed unless the prescription is labeled "Dispense as Written," (DAW).
- , The reimbursement for prescription drugs is the average wholesale price (AWP) + a \$4 dispense fee for each prescription drug. **Not more than one dispense fee shall be paid for each drug every 10 days.**
- , **A bill for a prescription drug shall include:**
 - a) Name of the drug and the manufacturer's name
 - b) Strength of the drug
 - c) Quantity and the dosage of the drug
 - d) Name and address of the pharmacy
 - e) Prescription number
 - f) Date dispensed
 - g) Prescriber of the medication
 - h) Patient name, address and social security number
 - i) National drug code as listed in Red Book

Supplies and durable medical equipment are reimbursed at AWP + not more than 50%.

The L-code procedures have fees established and are printed in the rules and published in this manual.

Modifiers

A modifier is a two-digit number added to a CPT procedure code to explain a specific set of circumstances. A two-alpha code may also be used to describe the practitioner providing the service. For certain services and circumstances the use of a modifier is required. The use of a modifier does not guarantee additional payment to the provider.

Submitting Claims for Payment

Providers are responsible for submitting claim forms to the carrier for payment. A carrier is defined as an insurance company or a self-insured employer or self-insured group fund or

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one of the Funds specified in the act. **When a provider is unable to get carrier information from the employer, contact the Bureau at 517-322-1885 with the following information:**

- , Employer name and address
- , Date of injury or date of first symptoms for reported illness

Collecting Medical Fees

The Bureau does not reimburse medical providers. The carrier (insurance companies, self-insured employers or self-insured group funds, or one of the funds specified in the Act) is responsible for payment of services. Contact the carrier to determine the status of the claim.

CHAPTER 4

Payment Policy

This chapter contains policies and procedures governing the payment of workers' compensation claims for medical services. The information herein will serve as a guide to payers when determining appropriate payment for medical claims.

General Payment Policy

The carrier is required to reimburse for all medically necessary and reasonable health services in accord with section 315 of the Workers' Disability Compensation Act. The medical services must be performed by licensed, registered or certified health care providers and services must be provided to the extent that licensure, registration or certification law allows.

The amount paid will be the Maximum Allowable Payment (MAP), in accord with the Rules, or the provider's usual and customary charge, whichever is less (this applies to modified services as well). Payment will be made only for actual services rendered for the covered work injury or illness.

Medical Services Rendered in Another State.

When services are rendered for Michigan workers by practitioners in states other than Michigan, the provider may or may not accept MAP made in accord with the Michigan fees. If an out-of-state provider requests reconsideration of payment, the carrier may attempt to negotiate the fee. However, if the provider refuses to negotiate fees, the carrier must reimburse the provider's charge. The worker is not responsible for any unpaid balances of the provider's charges and should be instructed to send any bills received to the carrier for resolution.

Workers' Compensation Laws are State-Specific

Workers' compensation laws in Michigan apply only to Michigan workers. A federal employee or an employee working for a company located outside of the state of Michigan would not be covered under Michigan law. A Michigan provider may only access the hearing system for workers' compensation for medical services rendered to Michigan workers.

When a provider treats a federal employee or a worker injured in another state's jurisdiction, the health services will be reimbursed in accord with either federal labor laws or those of the specific state where the employee worked.

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Claims Review and Reduction

A carrier must ensure that their technical review programs (data software) result in correct payments in accord with the maximum allowable payment (MAP) amounts outlined in the Rules.

A carrier shall perform utilization review for medical services to ensure that those services are necessary, reasonable and related to the work injury or illness. Utilization review must be performed by licensed, registered or certified health care professionals, and when necessary, peer review of medical services shall be completed by the carrier to support their utilization decisions.

The carrier is responsible for reviewing the claims for compensability and that the services are necessary and reasonable. Each carrier must provide professional review of the medical services whenever the charges on a case exceed \$5,000.00, there is an inpatient admission or on any case deemed appropriate by the carrier.

Services Not Substantiated by Documentation

In a case where the reviewer cannot find evidence in the notes or operative report that the service was performed, the charge for that service may be denied. The EOB must indicate the reason for the denial.

Services Not Accurately Coded

When a service billed is supported by documentation but the code selected by the provider is not the most accurate code available to describe that service, the disputed amount shall be limited to the amount of the difference between the MAP of the code billed, and the MAP of the code recommended by the reviewer. Therefore, the reviewer must not deny payment for the service but recommend a payment based on the more accurate code.

The carrier may not take the position that the provider's acceptance of payment constitutes agreement with the decision. The provider has the right to dispute the decision requesting reconsideration and a hearing if not resolved through reconsideration.

Examples of Common Coding Errors Include:

- , An office visit is coded at a higher level than substantiated by the medical record

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- , Two x-ray codes are billed when a single x-ray code describes the number of views taken
- , A debridement code is billed with another code whose descriptor includes the debridement

Providers can reduce the frequency of services being re-coded by following CPT guidelines for correct coding and guidelines found in the Health Care Services Rules.

Determining Payment for By Report (BR) Services

Supplies and durable medical equipment are "by report" (BR) and require a description of the service when billed. Reimbursement for the supplies and durable medical equipment are AWP + not more than 50%.

Ancillary services (dental, hearing, vision, and home health services) and services without an assigned RVU are reimbursed at a reasonable amount or the provider's usual and customary charge whichever is less. **Reasonable is defined for the purposes of reimbursement as "a payment based upon the amount generally paid in the state for a particular procedure code using data available from the provider, the carrier, or the Bureau."**

A provider may request reconsideration when the BR service is not reasonably reimbursed.

Multiple Patient Visits

Unless substantiated by medical necessity, only one patient visit per day, per provider may be paid. Generally when a provider sees a patient twice in one day for necessary services, the value of the visits are added together and a higher level of service is billed.

Separate Procedures

Certain services carry the designation "**separate procedure**" in their CPT descriptor. These are services that are commonly performed as an integral part of a total service and, as such, must not be paid as a separate procedure. When a "separate procedure" is performed independently of, and not immediately related to, other services, it may be billed and paid.

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Total Procedures Billed Separately

Certain diagnostic procedures (neurologic testing, radiology and pathology procedures, etc.) frequently are performed by two separate providers who will submit a separate claim for the professional and technical components. When this occurs, payment will be made according to the professional and technical components.

The billing procedures in Chapters 6-13 stipulate that providers must indicate on the claim form that the technical and professional components were performed separately by adding a modifier to the CPT code. Modifier -26 indicates that only the professional component was performed; modifier -TC indicates that only the technical component was performed.

Completion of the (EOB)

The Explanation of Benefits (EOB) must be sent to the provider with a copy sent to the worker. The carrier shall ensure that the following information is included on the EOB.

- , The provider charge, reimbursement allowed and reason for the reduction. The carrier may use a "reason code" but must clearly provide a written explanation.
- , The EOB should tell the provider how to request reconsideration and what information is needed.
- , If the check is not sent with the EOB there must be information included so that the provider can relate specific payment to the applicable services (claimant, procedure and date of service).

Disputed Payments

When a provider is dissatisfied with a payer's reduction or denial of a charge for a work related medical service, the provider may submit to the carrier a **written request for reconsideration *within 60 days of receipt of payment***. The request must include a detailed explanation for the disagreement and documentation to substantiate the charge/service in question. Providers may not dispute a payment because of dissatisfaction with a MAP amount. Refer to Part 13 of the Rules for resolving differences. When the provider is dissatisfied with payments resulting from contractual agreements, the provider must refer to that agreement and not enter into the hearing system for workers' compensation.

Upon receipt of a request for reconsideration, the payer must review and re-evaluate the original bill and accompanying documentation, using its own medical consultant or peer

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review if necessary, and respond to the provider within 30 days of the date of receipt. The payer's response to the provider must explain the reason(s) behind the decision and cite the specific policy or rule upon which the adjustment was made.

Mediation Applications (104B's)

Medical providers, insurance companies, and self-insured employers may request a mediation hearing through the Bureau by submitting the form, "Application for Mediation and Hearing" (104B). A carrier may request a hearing to recover overpayments (refer to Rule 119), however the hearings are most frequently requested by providers of health care services when those services have not been correctly paid. An injured worker may not use the 104B to request a hearing or contest his case. The injured worker with questions should be instructed to call the Bureau at (517)241-8999 or (888)396-5041 if he has questions.

A Provider's reasons for requesting mediation hearings:

- , No response to the provider's bill
- , Payment dispute unresolved through the reconsideration process
- , A provider **should** file a 104B whenever he learns that the workers' case is contested (the carrier denied compensability and the worker filed a 104A Form).

Note: When an injured worker does not dispute the carrier's denial of a case by submitting a 104A to the Bureau, the worker or his health insurance is responsible for the health services. A worker may not be turned over to collections if there is a pending worker's compensation claim that has not been resolved by the magistrate.

The original form (orange) is mailed to the Bureau by the requesting party with a copy sent to either the carrier or provider as appropriate. **The 104B form may be obtained from the Bureau.** Documentation is not sent to the Bureau with the application but is taken to the mediation site.

Ordering Forms

Bureau forms including 104B forms are obtained from the bureau. You may order forms by one of the one of the following:

- < mail request to BWDC, PO Box 30016, Lansing MI 48909

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- < email to bwdcinfo@cis.state.mi.us
- < fax (517)322-1808.

All requests should include a contact name and phone number, company name , street address, city, state, zip, the requested form and quantity.

CHAPTER 5

Completing and Submitting Claims

This chapter contains specific instructions for completing medical claim forms. Failure to provide the information in the manner requested herein may result in claims being returned for correction, additional information or denial.

Claims Prepared by a Billing Service

Claims prepared for a provider by a billing service must comply with all applicable sections of this manual.

Completing the HCFA-1500 for Practitioner Billing

The HCFA-1500 is the standard claim form used for practitioner services. The instructions listed below indicate the information required to process practitioner claims for workers' compensation cases. The HCFA 155 (12-90) is the most recent format and the preferred form.

Note: Radiologists, pathologists, ambulance services, and anesthesiologists are not required to enter a diagnostic code.

HCFA-1500 (12-90) Claim Form Elements 1 through 33

1. Mark other
- 1a. Patient's social security number
2. Name of the patient
3. Patient's sex and date of birth
4. Name of the workers' disability compensation carrier
5. Patient's complete address omitting the telephone number
6. Omit
7. Carrier address. Omit the telephone number
8. Omit
9. Enter the employer's name
- 9a. Omit
- 9b. Omit
- 9c. Omit
- 9d. Omit
10. Mark the appropriate boxes
11. Omit

HCFA 12-90 continued

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- 11a. Omit
- 11b. Omit
- 11c. Omit
- 11d. Omit
- 12. Omit
- 13. Omit
- 14. Date of the work-related accident or the first symptoms of work-related illness
- 15. Complete if appropriate and if known
- 16. Enter the month, day, and year if applicable
- 17. Name of the referring physician
- 17a. Omit
- 18. Date if applicable
- 19. Omit
- 20. Mark appropriate box
- 21. Written diagnosis of the ICD-9-CM diagnostic code number
- 22. Omit
- 23. Omit
- 24a. Date for each service, "from/to" dates may be utilized
- 24b. Place of service code
- 24c. Type of service code
- 24d. Enter the procedure code and modifier if appropriate. Attach documentation to explain unusual circumstances
- 24e. ICD-9-CM diagnostic code number
- 24f. Charge for each procedure billed
- 24g. Complete this column for multiple units or total minutes for anesthesia services
- 24h. Enter "DB" for duplicate bill with the date billed
- 24i. Omit
- 24j. Omit
- 24k. Omit
- 25. Enter the provider's FEIN
- 26. Enter the patient's account or case number
- 27. Omit
- 28. Enter the total charges
- 29. Omit
- 30. Omit
- 31. Enter the date of the bill
- 32. Complete if applicable
- 33. Practitioner's name, license, registration, or certification number, address, zip code, telephone number

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Site of Service Codes Place in element 24b on the HCFA 1500 (12-90)

- 1 or 21 - Inpatient hospital.
- 2 or 22 - Outpatient hospital.
- 3 or 11 - Office or clinic.
- 4 or 12 - Patient home.
- 5 or 52 - Day care facility (psychiatric facility/part hospital).
- 7 or 32 - Nursing home/nursing facility.
- 8 or 31 - Skilled nursing facility.
- 9 or 41 - Ambulance (land).
- 0 or 99 - Other locations (other unlisted facility).
- A or 81 - Independent laboratory.
- B or 24 - Other medical/surgical facility (free-standing outpatient surgical center).
- C - Residential treatment center (adult foster care).
- G or 23 - Emergency room - hospital.
- J or 33 - Custodial care.
- K or 34 - Hospice.
- L or 42 - Ambulance (air or water).
- M or 51 - Inpatient psychiatric facility.
- N or 53 - Community mental health.
- O or 56 - Psychiatric residential facility.

Type of service codes Place in element 24c on the HCFA 1500 (12-90)

- 1 - Medical care.
- 2 - Surgery.
- 3 - Consultation.
- 4 - Diagnostic x-ray.
- 5 - Diagnostic laboratory.
- 6 - Radiation therapy.
- 7 - Anesthesia.
- 8 - Assistance at surgery.
- 9 - Other medical service.
- 0 - Blood or packed red cells.
- A - Used durable medical equipment.
- F - Ambulatory surgical center.
- H - Hospice.
- L - Renal supplies in the home.

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American Dental Association Claim Form

In the top two boxes:

Left. Mark appropriate box, pre-treatment estimate or statement of actual services.

Right. Enter the workers' compensation carrier name and address.

Item 1. Patient Name, First, M.I., Last

Item 2. Mark "self."

Item 3. Enter the sex of the patient.

Item 4. Enter patient's birth date (MMDDYYYY).

Item 5. Omit.

Item 6. Enter the patient's complete mailing address.

Item 7. Enter the patient's social security number.

Item 8. Omit.

Item 9. Enter employer's name.

Item 10. Enter the employer's complete mailing address.

Item 11. Omit.

Item 12-a. Omit.

Item 12-b. Omit.

Item 13. Omit.

Item 14-a. Omit.

Item 14-b. Omit.

Item 14-c. Omit.

Item 15. Omit.

Item 16. Enter the name of the dentist or dental organization.

Item 17. Enter the dentist's or dental organization's complete address.

Item 18. Enter the dentist's social security number or dental organization's FEIN.

Item 19. Enter the dentist's license number.

Item 20. Enter the dentist's telephone number.

Item 21. Enter the first visit for the current series of treatment.

Item 22. Mark appropriate box for place of treatment.

Item 23. Indicate if x-rays are enclosed and how many.

Item 24-30. Mark appropriate boxes. In item 24. enter the date of injury

Item 31. Enter the tooth number, a description of the service, the date of service, the procedure number, and the fee.

Item 32. Indicate with an "x" any missing teeth. Add remarks for unusual services. Include any dental disorders that existed before the date of injury.

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Facility Billing

Licensed facilities are to submit facility charges on the UB-92 claim form in accord with the billing instructions provided in the UB-92 billing manual published by the Michigan Health and Hospital Association. The workers' compensation carrier is responsible for ensuring that the form is properly completed prior to payment. **A copy of the UB-92 billing manual can be obtained by contacting:**

Michigan Health & Hospital Association
Att: UB-92 Manual Subscription
6215 W St. Joseph Hwy.
Lansing MI 48917
(517)323-3443

Hospitals must submit charges for practitioner services on the HCFA 1500 claim form. Examples of practitioner services billed by the hospital are:

- , Anesthesiologists or nurse practitioners
- , Radiologists
- , Hospital-owned physician practices
- , Hospital-owned occupational or industrial clinics