

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

WORKERS' COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

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These rules take effect 7 days after filing with the Secretary of State

(By authority conferred on the workers' compensation agency by sections 205 and 315 of 1969 PA 317, section 33 of 1969 PA 306, Executive Reorganization Order Nos. 1982-2, 1986-3, 1990-1, 1996-2, 2003-1, and 2011-4, MCL 418.205, 418.315, 24.233, 18.24, 418.1, 418.2, 445.2001, 445.2011, and 445.2030)

R 418.10106, R 418.10107, R 418.10108, R 418.10109, R 418.10207, R 418.10214, R 418.10401, R 418.10404, R 418.10504, R 418.10701, R 418.10901, R 418.10902, R 418.10904, R 418.10912, R 418.10920, R 418.10921, R 418.10922, R 418.10923b, R 418.10925, R 418.101002, R 418.101003, R 418.101003a, R 418.101003b, R 418.101004, R 418.101006, R 418.101007, R 418.101023, R 418.101301, R 418.101401, R 418.101501, R 418.101503 of the Michigan Administrative Code are amended, and R 418.10902a, R 418.101008, R 418.101008a, R 418.101008b, R 418.101009 are added, and R 418.101002a is rescinded, as follows:

PART 1. GENERAL PROVISIONS

R 418.10106 Procedure codes; relative value units; other billing information.

Rule 106. (1) Upon annual promulgation of R 418.10107, the health care services division of the workers' compensation agency shall provide separate from these rules a manual, tables, and charts containing all of the following information on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca):

(a) All Current Procedural Terminology (CPT®) procedure codes used for billing health care services.

(b) Medicine, surgery, and radiology procedures and their associated relative value units.

(c) Hospital maximum payment ratios.

(d) Billing forms and instruction for completion.

(2) The procedure codes and standard billing and coding instructions for medicine, surgery, and radiology services shall be adopted from the most recent publication entitled "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107. However, billing and coding guidelines published in the CPT codebook do not guarantee reimbursement. A carrier shall only reimburse medical procedures for a work-related injury or illness that are reasonable and necessary and are consistent with accepted medical standards.

(3) The formula and methodology for determining the relative value units shall be adopted from the "Medicare RBRVS Fee Schedule" as adopted by reference in R 418.10107 using geographical information for the state of Michigan. The geographical information, (GPCI), for these rules is a melded average using 60% of the figures published for the city of Detroit added to 40% of the figures published for the rest of this state.

(4) The maximum allowable payment for medicine, surgery, and radiology services shall be determined by multiplying the relative value unit assigned to the procedure times the conversion factor listed in the reimbursement section, part 10 of these rules.

(5) Procedure codes from "HCPCS 2014 Level II Professional Edition" as adopted by reference in R 418.10107 shall be used to describe all of the following services:

- (a) Ambulance services.
- (b) Medical and surgical expendable supplies.
- (c) Dental procedures.
- (d) Durable medical equipment.
- (e) Vision and hearing services.
- (f) Home health services.

(6) Medical services shall be considered "By Report" (BR) if a procedure code listed in "HCPCS 2014 Level II Professional Edition" or "Current Procedural Terminology (CPT®) 2014 Professional Edition" as adopted by reference in R 418.10107 does not have an assigned value.

R 418.10107 Source documents; adoption by reference.

Rule 107. The following documents are adopted by reference in these rules and are available for distribution from the indicated sources, at the cost listed in subdivisions (a) to (h) of this rule:

(a) "Current Procedural Terminology (CPT®) 2014 Professional Edition," published by the American Medical Association, P.O. Box 930876, Atlanta GA, 31193-0876, item #EP888814, 1-800-621-8335. The publication may be purchased at a cost of \$114.95 plus \$16.95 shipping and handling as of the time of adoption of these rules. Permission to use this publication is on file in the workers' compensation agency.

(b) "HCPCS 2014 Level II Professional Edition," published by the American Medical Association, P.O. Box 930876 Atlanta GA 31193-0876, item #OP231514, customer service 1-800-621-8335. The publication may be purchased at a cost of \$96.95, plus \$11.95 for shipping and handling, as of the time of adoption of these rules.

(c) "Medicare RBRVS 2014: The Physicians' Guide," 23<sup>rd</sup> edition, published by The American Medical Association, P.O. Box 930876, Atlanta GA 31193-0876, item #OP059614, 1-800-621-8335, available February 2014. The publication may be purchased at a cost of \$91.95, plus \$11.95 shipping and handling, as of the time of adoption of these rules.

(d) "International Classification of Diseases, ICD-9-CM 2014 Professional Edition for Physicians, Volumes 1 and 2," American Medical Association, P.O. Box 930876, Atlanta GA 31193-0876, item # OP065114, 1-800-621-8335. The publication may be purchased at a cost of \$92.95, plus \$11.95 shipping and handling, as of the time of adoption of these rules.

(e) "International Classification of Diseases, ICD-10-CM 2014: The Complete Official Draft Code Set," American Medical Association, P.O. Box 930876, Atlanta, GA 31193-

0876, item # OP201414, 1-800-621-8335. The publication may be purchased at a cost of \$99.95, plus \$11.95 shipping and handling, as of the time of adoption of these rules.

(f) Red Book Online subscription service of Truven Health Analytics, contact:

<http://www.redbook.com/redbook/online/>.

(g) Medi-Span Drug Information Database, a part of Wolters Kluwer Health, contact:

<http://www.medispan.com>.

(h) "Official UB-04 Data Specifications Manual 2014, July 1, 2013" developed in cooperation with the American Hospital Association's National Uniform Billing committee, published by American Hospital Association, National Uniform Billing Committee - UB-04, P.O. Box 92247, Chicago, IL 60675-2247, 1-312-422-3390. As of the time of adoption of these rules, the cost of this eBook for a single user is \$155.00 and is available at [www.nubc.org](http://www.nubc.org).

R 418.10108 Definitions; A to I.

Rule 108. As used in these rules:

(a) "Act" means the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941.

(b) "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment to the maximum fee allowed by these rules, to a provider's usual and customary charge, or, when the maximum fee is by report, to a reasonable amount. "Adjust" also means when a carrier re-codes a procedure, or reduces payment as a result of professional review.

(c) "Agency" means the workers' compensation agency in the department of licensing and regulatory affairs.

(d) "Ambulatory surgical center" (ASC) means an entity that operates exclusively for providing surgical services to patients not requiring hospitalization and has an agreement with the centers for Medicare and Medicaid services (CMS) to participate in Medicare.

(e) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.

(f) "Biologics" or "biologicals" include drugs or other products that are derived from life forms. Biologics are biology-based products used to prevent, diagnose, treat, or cure disease or other conditions in humans and animals. Biologics generally include products such as vaccines, blood, blood components, allergenics, somatic cells, genes, proteins, DNA, tissues, skin substitutes, recombinant therapeutic proteins, microorganisms, antibodies, immunoglobins, and others, including, but not limited to, those that are produced using biotechnology and are made from proteins, genes, antibodies, and nucleic acids.

(g) "BR" or "by report" means that the procedure is not assigned a relative value unit, (RVU) or a maximum fee and requires a written description.

(h) "Carrier" means an organization that transacts the business of workers' compensation insurance in Michigan and which may be any of the following:

(i) A private insurer.

(ii) A self-insurer.

(iii) One of the funds in chapter 5 of the act, MCL 418.501 to 408.561.

(i) "Case" means a covered injury or illness that occurs on a specific date and is identified by the worker's name and date of injury or illness.

(j) "Case record" means the complete health care record that is maintained by a carrier and pertains to a covered injury or illness that occurs on a specific date.

(k) "Complete procedure" means a procedure that contains a series of steps that are not to be billed separately.

(l) "Covered injury or illness" means an injury or illness for which treatment is mandated by section 315 of the act, MCL 418.315.

(m) "Current procedural terminology (CPT®)" means a listing of descriptive terms and identifying codes and provides a uniform nationally accepted nomenclature for reporting medical services and procedures. The CPT codebook provides instructions for coding and claims processing.

(n) "Custom compound" as used in these rules, means a customized topical medication prescribed or ordered by a duly licensed prescriber for the specific patient that is prepared in a pharmacy by a licensed pharmacist in response to a licensed practitioner's prescription or order, by combining, mixing, or altering of ingredients, but not reconstituting, to meet the unique needs of an individual patient.

(o) "Dispute" means a disagreement between a carrier or a carrier's agent and a health care provider on the application of these rules.

(p) "Durable medical equipment" means specialized equipment that is designed to stand repeated use, is used to serve a medical purpose, and is appropriate for home use.

(q) "Emergency condition" means that a delay in treating a patient would lead to a significant increase in the threat to the patient's life or to a body part.

(r) "Established patient" means a patient whose medical and administrative records for a particular covered injury or illness are available to the provider.

(s) "Expendable medical supply" means a disposable article that is needed in quantity on a daily or monthly basis.

(t) "Facility" means an entity licensed by the state pursuant to the public health code, 1978 PA 368, MCL 333.1101 to 333.25211. The office of an individual practitioner is not considered a facility.

(u) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.

(v) "Follow-up days" means the days of care following a surgical procedure that are included in the procedure's maximum allowable payment, but does not include care for complications. If the surgical procedure lists "xxx" for the follow-up days, then the global concept does not apply. If "yyy" is listed for follow-up days, then the carrier shall set the global period. If "zzz" is used, then the procedure code is part of another service and falls within the global period of the other service.

(w) "Free standing outpatient facility" (FSOF) means a facility, other than the office of a physician, dentist, podiatrist, or other private practice, offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient hospital care.

(x) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes any of the following:

- (i) Health maintenance organization.
- (ii) Industrial or other clinic.
- (iii) Occupational health care center.

(iv) Home health agency.

(v) Visiting nurse association.

(vi) Laboratory.

(vii) Medical supply company.

(viii) Community mental health board.

(y) "Health care review" means the review of a health care case or bill, or both, by a carrier, and includes technical health care review and professional health care review.

(z) "Incidental surgery" means a surgery that is performed through the same incision, on the same day, by the same doctor of dental surgery, doctor of medicine, doctor of osteopathy, or doctor of podiatry and that is not related to diagnosis.

(aa) "Independent medical examination" means an examination and evaluation that is requested by a carrier or an employee and that is conducted by a different practitioner than the practitioner who provides care.

(bb) "Industrial medicine clinic" also referred to as an "occupational health clinic" means an organization that primarily treats injured workers. The industrial medicine clinic or occupational clinic may be a health care organization as defined by these rules or may be a clinic owned and operated by a hospital for the purposes of treating injured workers.

(cc) "Insured employer" means an employer who purchases workers' compensation insurance from an insurance company that is licensed to write insurance in the state of Michigan.

#### R 418.10109 Definitions; M to U.

Rule 109. As used in these rules:

(a) "Maximum allowable payment" means the maximum fee for a procedure that is established by these rules, a reasonable amount for a "by report" procedure, or a provider's usual and customary charge, whichever is less.

(b) "Medical only case" means a case that does not involve wage loss compensation.

(c) "Medical rehabilitation" means, to the extent possible, the interruption, control, correction, or amelioration of a medical or a physical problem that causes incapacity through the use of appropriate treatment disciplines and modalities that are designed to achieve the highest possible level of post-injury function and a return to gainful employment.

(d) "Medically accepted standards" means a measure that is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services ensuring that the health care is suitable for a particular person, condition, occasion, or place.

(e) "Morbidity" means the extent of illness, injury, or disability.

(f) "Mortality" means the likelihood of death.

(g) "New patient" means a patient who is new to the provider for a particular covered injury or illness and who needs to have medical and administrative records established.

(h) "Nursing home" means a nursing care facility, including a county medical care facility, created pursuant to section 20109, 1978 PA 368, MCL 333.20109.

(i) "Opioid drugs" as used in these rules, refers to opiate analgesics, narcotic analgesics, or any other Schedule C (II-III) controlled substance as identified in United States Code Controlled Substances Act of 1970, 21. U.S.C. §812. Opioid analgesics are the class of drugs, such as morphine, codeine, and methadone, that have the primary indication for the relief of pain.

(j) "Orthotic equipment" means an orthopedic apparatus that is designed to support, align, prevent, or correct deformities of, or improve the function of, a movable body part.

(k) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

(l) "Practitioner" means an individual who is licensed, registered, or certified as used in the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(m) "Primary procedure" means the therapeutic procedure that is most closely related to the principal diagnosis and has the highest assigned relative value unit (RVU).

(n) "Properly submitted bill" means a request by a provider for payment of health care services that is submitted to a carrier on the appropriate completed claim form with attachments as required by these rules.

(o) "Prosthesis" means an artificial substitute for a missing body part. A prosthesis is constructed by a "prosthetist", a person who is skilled in the construction and application of a prosthesis.

(p) "Provider" means a facility, health care organization, or a practitioner.

(q) "Reasonable amount" means 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 workers' compensation agency, health care services division.

(r) "Restorative" means that the patient's function will demonstrate measurable improvement in a reasonable and generally predictable period of time and includes appropriate periodic care to maintain the level of function.

(s) "Secondary procedure" means a surgical procedure that is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.

(t) "Separate procedure" means procedures or services listed in the CPT code set that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of a term "separate procedure."

(u) "Specialist" means any of the following entities that are board-certified, board-eligible, or otherwise considered an expert in a particular field of health care by virtue of education, training, and experience generally accepted in that particular field:

(i) A doctor of chiropractic.

(ii) A doctor of dental surgery.

(iii) A doctor of medicine.

(iv) A doctor of optometry.

(v) A doctor of osteopathic medicine and surgery.

(vi) A doctor of podiatric medicine and surgery.

(v) "Subrogation" means substituting 1 creditor for another. An example of subrogation in workers' compensation is when a case is determined to be workers' compensation and the health benefits plan has already paid for the service and is requesting the workers' compensation carrier or the provider to refund the money that the plan paid on behalf of the worker.

(w) "Technical surgical assist" means that additional payment for an assistant surgeon, referenced in R 418.10416, is allowed for certain designated surgical procedures. The

Health Care Services Manual, published annually by the workers' compensation agency, denotes a surgical procedure allowing payment for the technical surgical assist with the letter "T."

(x) "Treatment plan" means a plan of care for restorative physical treatment services that indicates the diagnosis and anticipated goals.

(y) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges which were previously billed separately and which are included in the package for that procedure as defined by these rules. A usual and customary charge for a procedure shall be calculated based on data beginning January 1, 2000.

## PART 2. MEDICINE

R 418.10207 Mental health services.

Rule 207. (1) A psychiatrist only, shall use procedure code 90792 to describe a psychiatric diagnostic evaluation with medical services, or shall use a new patient evaluation and management code instead of 90792 to describe a psychiatric diagnostic evaluation. A psychologist shall use procedure code 90791 to describe a diagnostic evaluation without medical services. Procedure codes 90791 and 90792 shall not be reported on the same day as a psychotherapy or evaluation and management service procedure code.

(2) A psychiatrist only, shall use add on procedure codes 90833, 90836 and 90838, which shall be reported in conjunction with an evaluation and management services code.

(3) An individual performing psychological testing shall report the services using procedure codes 96101-96125.

(4) Mental health providers shall use the following modifiers to describe the practitioner providing the health services:

- (a) -AH, for services provided by a licensed psychologist.
- (b) -AL, for services provided by a limited licensed psychologist.
- (c) -AJ, for services provided by a certified social worker.
- (d) -LC, for services provided by a licensed professional counselor.
- (e) -CS, for services provided by a limited licensed counselor.
- (f) -MF, for services provided by a licensed marriage and family therapist.
- (g) -ML, for services provided by a limited licensed marriage and family therapist.

R418.10214 Orthotic and prosthetic equipment.

Rule 214. (1) A copy of a prescription by 1 of the following is required for prosthetic and orthotic equipment:

- (a) A doctor of medicine.
  - (b) A doctor of osteopathic medicine and surgery.
  - (c) A doctor of chiropractic.
  - (d) A doctor of podiatric medicine and surgery.
- (2) Orthotic equipment may be any of the following:
- (a) Custom-fit.
  - (b) Custom-fabricated.
  - (c) Non-custom supply that is prefabricated or off-the-shelf.

(3) A non-custom supply shall be billed using procedure code 99070, appropriate L-codes or A4570 for a prefabricated orthosis.

(4) An orthotist or prosthetist that is certified by the American board for certification in orthotics and prosthetics shall bill orthosis and prostheses that are custom-fabricated, molded to the patient, or molded to a patient model. Licensed physical and licensed occupational therapists may bill orthoses using L-codes within their discipline's scope of practice. In addition, a doctor of podiatric medicine and surgery may bill for a custom fabricated or custom-fit, or molded patient model foot orthosis using procedure codes L3000-L3649.

(5) If a licensed occupational therapist or licensed physical therapist constructs an extremity orthosis that is not adequately described by another L-code, then the therapist shall bill the service using procedure code L3999. The carrier shall reimburse this code as a "by report" or "BR" procedure. The provider shall include the following information with the bill:

(a) A description of the orthosis.

(b) The time taken to construct or modify the orthosis.

(c) The charge for materials, if applicable.

(6) L-code procedures shall include fitting and adjustment of the equipment.

(7) The health care services division shall provide the maximum allowable payments for L-code procedures separate from these rules on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca). If an L-code procedure does not have an assigned maximum allowable payment, then the procedure shall be by report, "BR."

(8) A provider may not bill more than 4 dynamic prosthetic test sockets without documentation of medical necessity. If the physician's prescription or medical condition requires utilization of more than 4 test sockets, then a report shall be included with the bill that outlines a detailed description of the medical condition or circumstances that necessitate each additional test socket provided.

#### PART 4. SURGERY

R 418.10401 Global surgical procedure; services included.

Rule 401. (1) The surgical procedures in the CPT code set as adopted in R 418.10107 always include the following list of specific services in addition to the surgical procedure.

(a) Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia.

(b) Subsequent to the decision for surgery, 1 related evaluation and management encounter on the date immediately prior to or on the date of the procedure is included. However, when an initial evaluation and management encounter occurs and a decision for surgery is made at that encounter, the evaluation and management service is payable in addition to the surgical procedure.

(c) Immediate postoperative care, including dictating operative notes, talking with the family and other physicians.

(d) Writing postoperative surgical orders in the patient's chart and dictating an operative report.

(e) Evaluating the patient in the postanesthesia recovery area.

(f) Typical, routine, normal postoperative follow-up care, including suture removal, during



the global period. The global period or follow-up days shall be provided separate from the rules on the agency website, [www.michigan.gov/wca](http://www.michigan.gov/wca).

(2) Intra-operative procedures required to perform the surgical service shall not be billed separately.

R 418.10404 Follow-up care occurring during global service.

Rule 404. (1) Follow-up care for a diagnostic procedure shall refer only to the days required to recover from the diagnostic procedure and not the treatment of the underlying condition.

(2) Follow-up care for therapeutic surgical procedures includes only that care which is usually part of the surgical service. Complications, exacerbations, recurrence, or the presence of other compensable diseases or injuries requiring additional services should be reported with the identification of appropriate procedures. The follow-up days for the surgical procedures are adopted from the "Medicare RBRVS The Physicians Guide," as referenced in R 418.10107(d). The follow-up days for each surgical procedure are provided separate from these rules on the agency website, [www.michigan.gov/wca](http://www.michigan.gov/wca). All of the following apply to the global service provider:

(a) If a carrier requests the surgeon to see an injured worker during the global service period for the purpose of job restrictions, job adjustments, or return to work, then the visit shall not be considered part of the global surgery package. If the carrier requests the visit, then the carrier shall prior authorize the visit assigning an authorization number. The provider shall bill the visit using procedure 99455 and modifier -32, including the authorization number in box 23 of the CMS 1500 form. The carrier shall not deny a prior authorized visit and shall reimburse the provider for the prior authorized visit. The maximum allowable payment for 99455-32 shall be listed in the manual published separate from these rules.

(b) The medical record shall reflect job adjustments, job restrictions or limitations, or return to work date, and the provider shall include the medical record with the bill.

(c) If an insured employer requests the surgeon to see an injured worker during the global surgery period for the purpose of job adjustments, restrictions, or return to work, then the employer shall obtain the prior authorization number from the carrier for the visit.

(3) Hospital follow-up care or a hospital visit by the practitioner responsible for the surgery shall be considered part of the surgical follow-up days listed for the procedure and shall not be paid as an independent procedure.

## PART 5. RADIOLOGY, RADIATION THERAPY, AND NUCLEAR MEDICINE

R 418.10504 Multiple procedure policy for radiology procedures.

Rule 504. (1) A multiple procedure payment reduction shall apply to specified radiology procedures when performed in a freestanding radiology office, a non-hospital facility, or a physician's office or clinic. The primary procedure, identified by the code with the highest relative value, shall be paid at 100% of the maximum allowable payment. If the provider's charge is less than the maximum allowable payment, then the service shall be paid at 100% of the provider's charge.

(2) The multiple procedure payment reduction shall apply when multiple radiological diagnostic imaging procedures are furnished to the same patient, on the same day, in the same session, by the same physician or group practice that has the same national provider

identifier. The agency shall publish in a manual separate from these rules a table listing the diagnostic imaging CPT codes subject to the multiple procedure payment reduction. When more than 1 procedure from the table is furnished to the same patient, on the same day, in the same session, by the same physician or group practice, the procedure with the highest relative value is paid at 100% of the maximum allowable payment. Each additional procedure shall have modifier -51 appended and the technical component shall be reduced to 50% of the maximum allowable payment, or the provider's charge, whichever is less, and the professional component shall be reduced to 75% of the maximum allowable payment, or the provider's charge, whichever is less.

## PART 7. DENTAL

R 418.10701 Scope.

Rule 701. (1) Dental services, related to, or resulting from, a covered work-related injury are covered under these rules. Incidental dental services are not covered.

(2) A dental provider shall bill services on a standard American dental claim form. The workers' compensation agency shall provide a copy of the claim form and instructions for completion separate from these rules in the health care services manual on the agency's website at [www.michigan.gov/wca](http://www.michigan.gov/wca).

(3) Dental services shall be reimbursed at either the dentist's usual and customary fee or reasonable fee, whichever is less.

## PART 9. BILLING

### SUBPART A. PRACTITIONER BILLING

R 418.10901 General information.

Rule 901. (1) All health care practitioners and health care organizations, as defined in these rules, shall submit charges on the proper claim form as specified in this rule. Copies of the claim forms and instruction for completion for each form shall be provided separate from these rules in a manual on the workers' compensation agency's website at [www.michigan.gov/wca](http://www.michigan.gov/wca). Charges shall be submitted as follows:

(a) A practitioner shall submit charges on the CMS1500 claim form.

(b) A doctor of dentistry shall submit charges on a standard dental claim form approved by the American dental association.

(c) A pharmacy, other than an inpatient hospital, shall submit charges on an invoice or an NCPDP Workers Compensation/Property & Casualty Universal Claim Form.

(d) A hospital-owned occupational or industrial clinic, or office practice shall submit charges on the CMS 1500 claim form.

(e) A hospital billing for a practitioner service shall submit charges on a CMS 1500 claim form.

(f) Ancillary service charges shall be submitted on the CMS 1500 claim form for durable medical equipment and supplies, L-code procedures, ambulance, vision, and hearing services. Charges for home health services shall be submitted on the UB-04 claim form.

(g) A shoe supplier or wig supplier shall submit charges on an invoice.

(2) A provider shall submit all bills to the carrier within 1 year of the date of service for consideration of payment, except in cases of litigation or subrogation.

(3) A properly submitted bill shall include all of the following appropriate documentation:

(a) A copy of the medical report for the initial visit.

(b) An updated progress report if treatment exceeds 60 days.

(c) A copy of the initial evaluation and a progress report every 30 days of physical treatment, physical or occupational therapy, or manipulation services.

(d) A copy of the operative report or office report if billing surgical procedure codes 10040-69990.

(e) A copy of the anesthesia record if billing anesthesia codes 00100-01999.

(f) A copy of the radiology report if submitting a bill for a radiology service accompanied by modifier -26. The carrier shall only reimburse the radiologist for the written report, or professional component, upon receipt of a bill for the radiology procedure.

(g) A report describing the service if submitting a bill for a "by report" procedure.

(h) A copy of the medical report if a modifier is applied to a procedure code to explain unusual billing circumstances.

R 418.10902 Billing for injectable medications, other than vaccines and toxoids, in office setting.

Rule 902. (1) The provider shall not bill the carrier for administration of therapeutic injections when billing an evaluation and management procedure code. If an evaluation and management procedure code is not listed, then the appropriate medication administration procedure code may be billed.

(2) The medication being administered shall be billed with either the unlisted drug and supply code from the CPT code set or the specific J-code procedure from Medicare's National Level II Codes as adopted by reference in R 418.10107.

(3) The provider shall list the NDC number for the medication in the upper shaded portion of box 24 of the CMS 1500.

(4) The carrier shall reimburse the medication at average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span, as adopted by reference in R 418.10107. No dispense fee shall be billed for injectable medications administered in the office setting.

(5) If the provider does not list the national drug code for the medication, the carrier shall reimburse the medication using the least costly NDC number by Red Book or Medi-Span for that medication.

R 418.10902a Billing for vaccines and toxoids in office setting.

Rule 902a. (1) When a provider administers a vaccine or toxoid in the office setting, both the vaccine and toxoid shall be billed as separate services. If a significantly separate evaluation and management service is performed, the appropriate evaluation and management service code shall be reported in addition to the vaccine or toxoid administration code pursuant to CPT codebook guidelines, as adopted by reference in R 418.10107.

(2) The vaccine or toxoid being administered and the administration of the vaccine or toxoid shall be billed using the applicable CPT procedure codes pursuant to CPT codebook guidelines, as adopted by reference in R 418.10107.

(3) The provider shall list the NDC number for the vaccine or toxoid in the upper shaded portion of box 24 of the CMS 1500.

(4) The carrier shall reimburse the vaccine or toxoid at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span, as adopted by reference in R 418.10107. No dispensing fee shall be billed for vaccines or toxoids administered in the office setting.

(5) If the provider does not list the NDC number for the vaccine or toxoid, the carrier shall reimburse the vaccine or toxoid using the least costly NDC number listed by Red Book or Medi-Span for that vaccine or toxoid.

R 418.10904 Procedure codes and modifiers.

Rule 904. (1) A health care service shall be billed with procedure codes adopted from "Current Procedural Terminology (CPT®) 2014 Professional Edition" or "HCPCS 2014 Level II Professional Edition," as referenced in R 418.10107. Procedure codes from the CPT code set shall not be included in these rules, but shall be provided on the workers' compensation agency's website at [www.michigan.gov/wca](http://www.michigan.gov/wca). Refer to "Current Procedural Terminology (CPT®) 2014 Professional Edition," as referenced in R 418.10107, for standard billing instructions, except where otherwise noted in these rules. A provider billing services described with procedure codes from "HCPCS 2014 Level II Professional Edition" shall refer to the publication as adopted by reference in R 418.10107 for coding information.

(2) The following ancillary service providers shall bill codes from "HCPCS 2014 Level II Professional Edition," as adopted by reference in R 418.10107, to describe the ancillary services:

- (a) Ambulance providers.
  - (b) Certified orthotists and prosthetists.
  - (c) Medical suppliers, including expendable and durable equipment.
  - (d) Hearing aid vendors and suppliers of prosthetic eye equipment.
- (3) A home health agency.

(4) If a practitioner performs a procedure that cannot be described by 1 of the listed CPT or HCPCS procedure codes, then the practitioner shall bill the unlisted procedure code. An unlisted procedure code shall only be reimbursed when the service cannot be properly described with a listed code and the documentation supporting medical necessity includes all of the following:

- (a) Description of the service.
- (b) Documentation of the time, effort, and equipment necessary to provide the care.
- (c) Complexity of symptoms.
- (d) Pertinent physical findings.
- (e) Diagnosis.
- (f) Treatment plan.

(5) The provider shall add a modifier code, found in Appendix A of the CPT codebook as adopted by reference in R 418.10107, following the correct procedure code describing unusual circumstances arising in the treatment of a covered injury or illness. When a modifier code is applied to describe a procedure, a report describing the unusual circumstances shall be included with the charges submitted to the carrier.

(6) Applicable modifiers from table 10904 shall be added to the procedure code to describe the type of practitioner performing the service. The required modifier codes for describing the practitioner are as follows:

Table 10904 Modifier Codes

- AA Anesthesia services performed personally by anesthesiologist.
- AH When a licensed psychologist bills a diagnostic service or a therapeutic service, or both.
- AJ When a certified social worker bills a therapeutic service.
- AL A limited license psychologist billing a diagnostic service or a therapeutic service.
- CS When a limited licensed counselor bills for a therapeutic service.
- GF Non-physician (nurse practitioner, advanced practice nurse or physician assistant) provides services in an office or clinic setting or in a hospital setting.
- LC When a licensed professional counselor performs a therapeutic service.
- MF When a licensed marriage and family therapist performs a therapeutic service.
- ML When a limited licensed marriage and family therapist performs a service.
- TC When billing for the technical component of a radiology service.
- QK When an anesthesiologist provides medical direction for not more than 4 qualified individuals being either certified registered nurse anesthetists or anesthesiology residents.
- QX When a certified registered nurse anesthetist performs a service under the medical direction of an anesthesiologist.
- QZ When a certified registered nurse anesthetist performs anesthesia services without medical direction.

R 418.10912 Billing for prescription medications.

Rule 912. (1) Prescription drugs may be dispensed to an injured worker by either an outpatient pharmacy or a health care organization as defined in these rules. These rules shall apply to the pharmacy dispensing the prescription drugs to an injured worker only after the pharmacy has either written or oral confirmation from the carrier that the prescriptions or supplies are covered by workers' compensation insurance.

(2) When a generic drug exists, the generic drug shall be dispensed. When a generic drug does not exist, the brand name drug may be dispensed. A physician may only write a prescription for "DAW", or dispense as written, when the generic drug has been utilized and found to be ineffective or has caused adverse effects for the injured worker. A copy of the medical record documenting the medical necessity for the brand name drug shall be submitted to the carrier.

(3) A bill or receipt for a prescription drug from an outpatient pharmacy, practitioner, or health care organization shall be submitted to the carrier and shall include the name, address, and social security number of the injured worker. An outpatient pharmacy shall bill the service using the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form or an invoice and shall include either the pharmacy's NPI or NCPDP number, and the NDC of the prescription drug.

(4) A health care organization or physician office dispensing the prescription drug shall bill the service on the CMS 1500 claim form. Procedure code 99070 shall be used to code the service and the national drug code shall be used to describe the drug.

(5) If an injured worker has paid for a prescription drug for a covered work illness, then the worker may send a receipt showing payment along with the drug information to the carrier for reimbursement.

(6) An outpatient pharmacy or health care organization shall include all of the following information when submitting a bill for a prescription drug to the carrier:

(a) The brand or chemical name of the drug dispensed.

(b) The NDC number from Red Book or Medi-Span as adopted by reference in R 418.10107.

(c) The dosage, strength, and quantity dispensed.

(d) The date the drug was dispensed.

(e) The physician prescribing the drug.

(7) A practitioner or a health care organization, other than an inpatient hospital, shall bill WC700-G to describe the dispense fee for each generic prescription drug and WC700-B to describe the dispense fee for each brand name prescription drug. A provider will only be reimbursed for 1 dispense fee for each prescription drug in a 10-day period. A dispense fee shall not be billed with "OTC"s, over-the-counter drugs.

418.10920 Billing for supplementary radiology supplies.

Rule 920. (1) If a description of a diagnostic radiology procedure includes the use of contrast materials, then those materials shall not be billed separately as they are included in the procedure.

(2) A radiopharmaceutical diagnostic low osmolar contrast materials and paramagnetic contrast materials shall only be billed when the CPT codebook instructions indicate supplies shall be listed separately.

(3) A supply for a radiology procedure shall be coded as provided in this rule. A provider shall include an invoice documenting the wholesale price of the contrast material used and the provider shall be reimbursed the wholesale price of the contrast material. Code Descriptor A4641 Supply of radiopharmaceutical diagnostic imaging agent Q9965 Supply of low osmolar contrast material, 100-199 mg/ml of iodine concentration per ml Q9966 Supply of low osmolar contrast material, 200-299 mg/ml of iodine concentration per ml Q9967 Supply of low osmolar contrast material, 300-399 mg/ml of iodine concentration per ml.

R 418.10921 Facility billing.

Rule 921. (1) Except for a freestanding surgical outpatient facility, a licensed facility as defined in these rules shall submit facility charges on a UB-04 claim form to the carrier. A copy of the UB-04 form shall be published separate from these rules in a manual provided on the agency's website at [www.michigan.gov/wca](http://www.michigan.gov/wca). The Official UB-04 Data-Specifications Manual referenced in these rules contains instructions for facility billing.

(2) A facility billing for a practitioner service shall bill charges on the CMS 1500 claim form.

R 418.10922 Hospital billing instructions.

Rule 922. (1) A hospital shall bill facility charges on the UB-04 national uniform billing claim form and shall include revenue codes, ICD.-9.-CM coding, until ICD-10-CM is implemented, then ICD-10-CM coding, HCPCS codes, and CPT® procedure codes to

identify the surgical, radiological, laboratory, medicine, and evaluation and management services. This rule only requires that the following medical records be attached when appropriate:

(a) Emergency room report.

(b) The initial evaluation and progress reports every 30 days whenever physical medicine, speech, and hearing services are billed.

(c) The anesthesia record when billing for a CRNA or anesthesiologist.

(2) A properly completed UB-04 shall not require attachment of medical records except for those in sub rule (1) of this rule to be considered for payment. Information required for reimbursement is included on the claim form. A carrier may request any additional records under R 418.10118.

(3) If a hospital clinic, other than an industrial or occupational medicine clinic, bills under a hospital's federal employer identification number, then a hospital clinic facility service shall be identified by using revenue code 510 "clinic."

(4) A hospital system-owned office practice shall bill services on the CMS 1500 claim form using the office site of service and shall not bill facility fees.

(5) A hospital or hospital system-owned industrial or occupational clinic providing occupational health services shall bill services on the CMS 1500 claim form using the office site of service and shall not bill facility fees.

R 418.10923b Billing for ambulatory surgery center (ASC) or freestanding surgical outpatient facility (FSOF).

Rule 923b. (1) An ASC or FSOF shall be licensed by the Michigan department of community health under part 208 of the code or if it has an agreement with the centers for Medicare and Medicaid services (CMS) to participate in Medicare. The owner or operator of the facility shall make the facility available to other physicians, dentists, podiatrists, or providers who comprise its professional staff. The following apply:

(a) When a surgery procedure is appropriately performed in the ASC or FSOF and CMS has not assigned a payment code for that procedure, the procedure shall be considered BR.

(b) The ASC or FSOF shall be reimbursed the maximum allowable paid for the payment code, taking into consideration the multiple procedure rule for facilities as defined by CMS.

(2) Billing instructions in this rule do not apply to a hospital-owned freestanding surgical outpatient facility billing with the same tax identification number as the hospital.

(3) An ASC or FSOF shall bill the facility services on the CMS 1500 claim form and shall include modifier SG to identify the service as the facility charge. The place of service shall be "24." The appropriate HCPCS or CPT procedure code describing the service performed shall be listed on separate lines of the bill.

(4) Modifier 50, generally indicating bilateral procedure, is not valid for the ASC or FSOF claim. Procedures performed bilaterally shall be billed on 2 separate lines of the claim form and shall be identified with modifiers, LT for left and RT for right.

(5) An ASC or FSOF shall only bill for outpatient procedures that, in the opinion of the attending physician, can be performed safely without requiring inpatient overnight hospital care and are exclusive of such surgical and related care as licensed physicians ordinarily elect to perform in their private offices.

(6) The payment for the surgical code includes the supplies for the procedure.

(7) Durable medical equipment, the technical component (-TC) of certain radiology services, certain drugs, and biologicals that are allowed separate payment under the outpatient prospective payment system (OPPS) will be provided separate from the rules on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca).

(8) Items implanted into the body that remain in the body at the time of discharge (such as plates, pins, screws, mesh) from the facility are reimbursable when they are designated by CMS as pass through items. These pass through items will be provided separate from these rules on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca). The facility shall bill implant items with the appropriate HCPCS code that is reimbursable under the OPPS. A report listing a description of the implant and a copy of the facility's cost invoice, including any full or partial credit given for the implant, shall be included with the bill.

(9) Those radiological services that are allowed separate payment under the OPPS will be provided separate from the rules on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca). When radiology procedures are performed intraoperatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and post-operative radiology services may be globally billed.

(10) At no time shall the ASC or FSOF bill for practitioner services on the facility bill.

(11) When an allowed drug or biological, provided separate from these rules on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca), is billed by the ASC or FSOF, it shall be listed by the appropriate HCPCS or CPT procedure code. All of the following apply:

- (a) Each allowable drug or biological shall be listed on a separate line.
- (b) Units administered shall be listed for each drug or biological.
- (c) A dispense fee shall not be billed.

R 418.10925 Billing requirements for other licensed facilities.

Rule 925. (1) A licensed facility, other than a hospital or freestanding surgical outpatient facility, shall bill the facility services on the UB-04 national uniform billing claim form and shall include the revenue codes contained in the Official UB-04 Data Specifications Manual, ICD-9-CM, until ICD-10-CM is implemented, then ICD-10-CM coding for diagnoses and procedures, and CPT procedure codes for surgical, radiological, laboratory, and medicine and evaluation and management services.

(2) Only the technical component of a radiological service or a laboratory service shall be billed on the standardized UB-04 national uniform billing claim form.

(3) All bills for the professional services shall be billed on a CMS 1500 claim form, using the appropriate CPT procedure code and modifier.

(4) A report describing the services provided and the condition of the patient shall be included with the bill.

PART 10. REIMBURSEMENT  
SUBPART A. PRACTITIONER REIMBURSEMENT



R 418.101002 Conversion factors for practitioner services.

Rule 1002. (1) The workers' compensation agency shall determine the conversion factors for medicine, evaluation and management, physical medicine, surgery, pathology, and radiology procedures. The conversion factor shall be used by the workers' compensation agency for determining the maximum allowable payment for medical, surgical, and radiology procedures. The maximum allowable payment shall be determined by multiplying the appropriate conversion factor times the relative value unit assigned to a procedure. The relative value units are listed for the medicine, surgical, and radiology procedure codes in a manual separate from these rules. The manual shall be published annually by the workers' compensation agency using codes adopted from "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107(a). The workers' compensation agency shall determine the relative values by using information found in the "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107(c).

(2) The conversion factor for medicine, radiology, and surgical procedures shall be \$47.19 for the year 2014 and shall be effective for dates of service on the effective date of these rules.

R 418.101002a Rescinded.

R 418.101003 Reimbursement for "by report" and ancillary procedures.

Rule 1003. (1) If a procedure code does not have a listed relative value, or is noted BR, then the carrier shall reimburse the provider's usual and customary charge or reasonable payment, whichever is less, unless otherwise specified in these rules.

(2) The following ancillary services are by report and the provider shall be reimbursed either at the practitioner's usual and customary charge or reasonable payment, whichever is less:

- (a) Ambulance services.
- (b) Dental services.
- (c) Vision and prosthetic optical services.
- (d) Hearing aid services.
- (e) Home health services.

(3) Orthotic and prosthetic procedures, L0000-L9999, shall be reimbursed by the carrier at Medicare plus 5%. The health care services division shall provide maximum allowable payments for L-code procedures separate from these rules on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca). Orthotic and prosthetic procedures with no assigned maximum allowable payment shall be considered by report procedures and require a written description accompanying the charges on the CMS-1500 claim form. The report shall include date of service, a description of the service or services provided, the time involved, and the charge for materials and components.

R 418.101003a Reimbursement for dispensed medications.

Rule 1003a. (1) Prescription medication shall be reimbursed at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span referenced in R 418.10107, plus a dispense fee. All of the following apply:

(a) The dispense fee for a brand name drug shall be \$3.50 and shall be billed with WC700-B.

(b) The dispense fee for a generic drug shall be \$5.50 and shall be billed with WC700-G.

(c) Reimbursement for repackaged pharmaceuticals shall be at a maximum reimbursement of AWP minus 10% based upon the original manufacturer's NDC number, as published by Red Book or Medi-Span, plus a dispensing fee of \$3.50 for brand name and \$5.50 for generic.

(d) All pharmaceutical bills submitted for repackaged products shall include the original manufacturer or distributor stock package national drug code or NDC number.

(e) When an original manufacturer's NDC number is not available in either Red Book or Medi-Span and a pharmaceutical is billed using an unlisted or "not otherwise specified code," the payer shall select the most closely related NDC number to use for reimbursement of the pharmaceutical.

(2) Over-the-counter drugs (OTC's), dispensed by a provider other than a pharmacy, shall be dispensed in 10-day quantities and shall be reimbursed at the average wholesale price, as determined by Red Book or Medi-Span or \$2.50, whichever is greater.

R 418.101003b Reimbursement for biologicals, durable medical equipment, and supplies.

Rule 1003b. (1) The carrier shall reimburse durable medical equipment (DME), supplies, and biologicals at Medicare plus 5%. The health care services division shall provide the maximum allowable payments for DME, supplies, and biologicals separate from these rules on the agency website, [www.michigan.gov/wca](http://www.michigan.gov/wca). Biologicals that have NDC numbers shall be billed and reimbursed under R 418.10912.

(2) Rented DME shall be identified on the provider's bill by RR. Modifier NU will identify the item as purchased, new.

(3) If a DME, supply, or biological exceeding \$35.00 is not listed in the fee schedule, or if the service is billed with a not otherwise specified code, then reimbursement shall be manufacturers' invoice cost plus a percent mark-up as follows:

(a) Invoice cost of \$35.01 to \$100.00 shall receive cost plus 50%.

(b) Invoice cost of \$100.01 to \$250.00 shall receive cost plus 30%.

(c) Invoice cost of \$250.01 to \$700.00 shall receive cost plus 25%.

(d) Invoice cost of \$700.01 or higher shall receive cost plus 20%.

R 418.101004 Modifier code reimbursement.

Rule 1004. (1) Modifiers may be used to report that the service or procedure performed has been altered by a specific circumstance but does not change the definition of the code. This rule lists procedures for reimbursement when certain modifiers are used. A complete listing of modifiers are listed in Appendix A of "Current Procedural Terminology CPT® 2014 Professional Edition," and Appendix A, section E of "HCPCS 2014 Level II Professional Edition" as adopted by reference in R 418.10107.

(2) When modifier code -25 is added to an evaluation and management procedure code, reimbursement shall only be made when the documentation provided supports the patient's condition required a significant separately identifiable evaluation and management service other than the other service provided or beyond the usual preoperative and postoperative care.

(3) When modifier code -26, professional component, is used with a procedure, the professional component shall be paid.

(4) If a surgeon uses modifier code -47 when performing a surgical procedure, then anesthesia services that were provided by the surgeon and the maximum allowable payment for the anesthesia portion of the service shall be calculated by multiplying the base unit of the appropriate anesthesia code by \$42.00. No additional payment is allowed for time units.

(5) When modifier code -50 or -51 is used with surgical procedure codes, the services shall be paid according to the following as applicable:

(a) The primary procedure at not more than 100% of the maximum allowable payment or the billed charge, whichever is less.

(b) The secondary procedure and the remaining procedure or procedures at not more than 50% of the maximum allowable payment or the billed charge, whichever is less.

(c) When multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body shall be reimbursed 100% of the maximum allowable payment or billed charge, whichever is less, and the second and remaining surgical procedure or procedures shall be identified by modifier code -51 and shall be reimbursed at 50% of the maximum allowable payment or billed charges, whichever is less.

(d) When modifier -50 or -51 is used with a surgical procedure with a maximum allowable payment of BR, the maximum allowable payment shall be 50% of the provider's usual and customary charge or 50% of the reasonable amount, whichever is less.

(6) The multiple procedure payment reduction shall be applied to the technical and professional component for more than 1 radiological imaging procedure furnished to the same patient, on the same day, in the same session, by the same physician or group practice. When modifier -51 is used with specified diagnostic radiological imaging procedures, the payment for the technical component of the procedure shall be reduced by 50% of the maximum allowable payment and payment for the professional component of the procedure shall be reduced to 75% of the maximum allowable payment. A table of the diagnostic imaging CPT procedure codes subject to the multiple procedure payment reduction shall be provided by the agency in a manual separate from these rules.

(7) When modifier code -TC, technical services, is used to identify the technical component of a radiology procedure, payment shall be made for the technical component only. The maximum allowable payment for the technical portion of the radiology procedure is designated on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca).

(8) When modifier -57, initial decision to perform surgery, is added to an evaluation and management procedure code, the modifier -57 shall indicate that a consultant has taken over the case and the consultation code is not part of the global surgical service.

(9) When both surgeons use modifier -62 and the procedure has a maximum allowable payment, the maximum allowable payment for the procedure shall be multiplied by 25%. Each surgeon shall be paid 50% of the maximum allowable payment times 25%, or 62.5 % of the MAP. If the maximum allowable payment for the procedure is BR, then the reasonable amount shall be multiplied by 25% and be divided equally between the surgeons.

(10) When modifier code -80 is used with a procedure, the maximum allowable payment for the procedure shall be 20% of the maximum allowable payment listed in these rules, or the billed charge, whichever is less. If a maximum payment has not been established and the

procedure is BR, then payment shall be 20% of the reasonable payment amount paid for the primary procedure.

(11) When modifier code -81 is used with a procedure code that has a maximum allowable payment, the maximum allowable payment for the procedure shall be 13% of the maximum allowable payment listed in these rules or the billed charge, whichever is less. If modifier code -81 is used with a BR procedure, then the maximum allowable payment for the procedure shall be 13% of the reasonable amount paid for the primary procedure.

(12) When modifier -82 is used and the assistant surgeon is a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine, or a doctor of dental surgery, the maximum level of reimbursement shall be the same as for modifier -80. If the assistant surgeon is a physician's assistant, the maximum level of reimbursement shall be the same as modifier -81. If a person other than a physician or a certified physician's assistant bills using modifier -82, then the charge and payment for the service is reflected in the facility fee.

(13) When modifier -GF is billed with evaluation and management or minor surgical services, the carrier shall reimburse the procedure at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less.

#### R 418.101006 Reimbursement for mental health services.

Rule 1006. (1) A carrier shall only reimburse procedure code 90792 and add on procedure codes 90833, 90836, and 90838 when billed by a psychiatrist who is either a medical doctor (M.D.) or a doctor of osteopathy (D.O.).

(2) A licensed psychologist or a limited license psychologist billing for a diagnostic procedure shall be paid the maximum allowable payment or the practitioner's usual and customary fee, whichever is less.

(3) A licensed psychologist billing for a therapeutic service shall use modifier -AH and shall be paid the maximum allowable payment or the practitioner's usual and customary charge, whichever is less.

(4) For the following providers, therapeutic mental health services shall be reimbursed at 85% of the maximum allowable payment, or the practitioner's usual and customary charge, whichever is less. If a procedure code has a maximum allowable payment of "by report," the maximum allowable payment shall be 85% of the reasonable payment, or the practitioner's usual and customary charge, whichever is less:

- (a) -AL limited license psychologist.
- (b) -AJ certified social worker.
- (c) -LC licensed professional counselor.
- (d) -MF licensed marriage and family therapist.

(5) For the following providers, mental health services shall be reimbursed at 64% of the maximum allowable payment, or the practitioner's usual and customary charge, whichever is less. If a procedure code has a maximum allowable payment of "by report," then the maximum allowable payment shall be 64% of the reasonable payment, or the practitioner's usual and customary charge, whichever is less:

- (a) -CS limited licensed counselor.
- (b) -ML limited licensed marriage and family therapist.

#### R 418.101007 Reimbursement for anesthesia services.

Rule 1007. (1) The carrier shall determine the maximum allowable payment for anesthesia services by adding the base units to the time units. The carrier shall reimburse anesthesia services at either the maximum allowable payment, or the practitioner's usual and customary charge, whichever is less. Each anesthesia base unit shall be multiplied by \$42.00 to determine payment for the base procedure.

(2) Anesthesia base units shall only be paid to an anesthesiologist, a surgeon who provides the anesthesia and performs the surgery, or a certified registered nurse anesthetist providing anesthesia without medical direction of the anesthesiologist. Only 1 practitioner shall be reimbursed for base units, documented by the anesthesia record.

(3) The carrier shall reimburse the time units by the total minutes listed in the "days" or "units" column and the alpha modifier added to the procedure code. Time units are reimbursed in the following manner:

(a) Increments of 15 minutes or portions thereof, for administration of the anesthesia.

(b) Increments of 30 minutes or portions thereof, for supervision of a CRNA.

(c) In no instance shall less than 1 time unit be reimbursed.

(4) The maximum allowable payment for anesthesia time shall be calculated in the following manner:

(a) If the anesthesiologist administers the anesthesia, then the modifier shall be -AA and the maximum payment shall be \$2.80 per minute.

(b) If the anesthesiologist supervises a CRNA, then the modifier shall be QK and the maximum payment shall be \$1.40 per minute.

(c) If a CRNA supervised by an anesthesiologist administers the anesthesia, then the modifier shall be -QX and the maximum payment shall be \$2.80 per minute.

(d) If a CRNA administers without supervision of the anesthesiologist, then the modifier shall be -QZ and the maximum payment shall be \$2.80 per minute.

R 418.101008 Reimbursement for opioid treatment for chronic, non-cancer pain.

Rule 1008. (1) For purposes of these rules, chronic pain is pain unrelated to cancer or is incident to surgery and that persists beyond the period of expected healing after an acute injury episode. It is pain that persists beyond 90 days following the onset of the pain. The payer shall reimburse for opioids used in the treatment of chronic pain resulting from work-related conditions.

2) This rule is applicable to opioid treatment of chronic pain for either of the following:

(a) For injury dates on or after 6 months following the effective date of these rules.

(b) For injury dates prior to the effective date, 12 months following the effective date.

R 418.101008a Required documentation for reimbursement of treatment for chronic, non-cancer pain with opioids.

Rule 1008a. (1) In order to receive reimbursement for opioid treatment beyond 90 days, the physician seeking reimbursement shall submit a written report to the payer not later than 90 days after the initial opioid prescription fill for chronic pain and every 90 days thereafter. The written report shall include all of the following:

(a) A review and analysis of the relevant prior medical history, including any consultations that have been obtained, and a review of data received from an automated prescription drug monitoring program in the treating jurisdiction, such as the Michigan Automated Prescription

System (MAPS), for identification of past history of narcotic use and any concurrent prescriptions.

(b) A summary of conservative care rendered to the worker that focused on increased function and return to work.

(c) A statement on why prior or alternative conservative measures were ineffective or contraindicated.

(d) A statement that the attending physician has considered the results obtained from appropriate industry accepted screening tools to detect factors that may significantly increase the risk of abuse or adverse outcomes including a history of alcohol or other substance abuse.

(e) A treatment plan which includes all of the following:

(i) Overall treatment goals and functional progress.

(ii) Periodic urine drug screens.

(iii) A conscientious effort to reduce pain through the use of non-opioid medications, alternative non-pharmaceutical strategies, or both.

(iv) Consideration of weaning the injured worker from opioid use.

(f) An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement shall be reviewed, updated, and renewed every 6 months. The opioid treatment agreement shall outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, and the responsibilities of the prescribing physician and the worker.

(2) The provider may bill the additional services required for compliance with these rules utilizing CPT procedure code 99215 for the initial 90 day report and all subsequent follow-up reports at 90-day intervals.

(3) Providers may bill \$25.00 utilizing code MPS01 for accessing MAPS or other automated prescription drug monitoring program in the treating jurisdiction.

R 418.101008b Denial of reimbursement for prescribing and dispensing opioid medications used to treat chronic, non-cancer pain.

Rule 1008b. Reimbursement for prescribing and dispensing opioid medications may be denied, pursuant to the act. Denial of reimbursement may occur if the physician reporting and treatment plan requirements as stated in R 418.101008a are not met. Denial of reimbursement shall occur only after a reasonable period of time is provided for the weaning of the injured worker from the opioid medications, and alternative means of pain management have been offered.

R 418.101009 Reimbursement for custom compounded topical medication.

Rule 1009. (1) Six months after the effective date of this rule, a custom compound topical medication, as defined in R418.10108, shall be reimbursed only when the compound meets all of the following standards:

(a) There is no readily available commercially manufactured equivalent product.

(b) No other FDA approved alternative drug is appropriate for the patient.

(c) The active ingredients of the compound each have an NDC number and are components of drugs approved by the United States Food and Drug Administration (FDA).

(d) The drug has not been withdrawn or removed from the market for safety reasons.

(e) The prescriber is able to demonstrate to the payer that the compound medication is clinically appropriate for the intended use.

(2) Topical compound drugs or medications shall be billed using the specific amount of each component drug and its original manufacturers' NDC number included in the compound. Reimbursement shall be based on a maximum reimbursement of the AWP minus 10% based upon the original manufacturer's NDC number, as published by Red Book or Medi-Span, and pro-rated for each component amount used. Components without NDC numbers shall not be reimbursed. A single dispensing fee for a compound prescription shall be \$12.50 for a non-sterile compound. The dispensing fee for a compound prescription shall be billed with code WC 700-C. The provider shall dispense a 30-day supply per prescription.

(3) Reimbursement for a custom compounded drug is limited to a maximum of \$600.00. Any charges exceeding this amount must be accompanied by the original component manufacturers' invoice pro-rated for each component amount used, for review by the carrier.

#### R 418.101023 Reimbursement for ASC or FSOF.

Rule 1023. (1) Reimbursement for surgical procedures performed in an ASC or FSOF shall be determined by using the ASC rate published by CMS. The formula for determining the maximum allowable paid (MAP) for a surgical procedure in an ASC or FSOF is determined by multiplying the (Medicare ASC rate) X (1.30). The MAP shall be published in the health care services fee schedule.

(2) When 2 or more surgical procedures are performed in the same operative session, the facility shall be reimbursed at 100% of the maximum allowable payment or the facility's usual and customary charge, whichever is less, for the procedure classified in the highest payment group. Any other surgical procedures performed during the same session shall be reimbursed at 50% of the maximum allowable payment or 50% of the facility's usual and customary charge, whichever is less. A facility shall not un-bundle surgical procedure codes when billing the services.

(3) When an eligible procedure is performed bilaterally, each procedure shall be listed on a separate line of the claim form and shall be identified with LT for left and RT for right. At no time shall modifier 50 be used by the facility to describe bilateral procedures.

(4) Implants are included in the maximum allowable paid unless the CMS list it as a pass through item. Pass through items will be provided on the agency's website, [www.michigan.gov/wca](http://www.michigan.gov/wca). If an item is implanted during the surgical procedure and the ASC or FSOF bills the implant and includes the copy of the invoice, then the implant shall be reimbursed at the cost of the implant plus a percent markup as follows:

(a) Cost of implant: \$1.00 to \$500.00 shall receive cost plus 50%.

(b) Cost of implant: \$500.01 to \$1000.00 shall receive cost plus 30%.

(c) Cost of implant: \$1000.01 and higher shall receive cost plus 25%.

(5) Laboratory services shall be reimbursed by the maximum allowable payment as determined in R 418.101503.

(6) When a radiology procedure is performed intra-operatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and post-operative radiology services may be globally billed.

(7) When the freestanding surgical facility provides durable medical equipment, the items shall be reimbursed in accord with R 418.101003b.

### PART 13. PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIER AND PROVIDER REGARDING BILLING

R 418.101301 Carrier's adjustment or rejection of properly submitted bill.

Rule 1301. (1) If a carrier adjusts or rejects a bill or a portion of the bill, then the carrier shall notify the provider within 30 days of the receipt of the bill of the reasons for adjusting or rejecting the bill or a portion of the bill and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action. The carrier shall set forth the specific reasons for adjusting or rejecting a bill or a portion of the bill and request specific information on a form, "Carrier's Explanation of Benefits," prepared by the agency pursuant to the reimbursement provisions in these rules.

(2) If the provider sends a properly submitted bill to a carrier and the carrier does not respond within 30 days, and if a provider sends a second properly submitted bill and does not receive a response within 60 days from the date the provider supplied the first properly submitted bill, then the provider may file an application with the agency for mediation or hearing. The provider shall send a completed form entitled "Application for Mediation or Hearing" to the agency and shall send a copy of this form to the carrier.

(3) The carrier shall notify the employee and the provider that the rules prohibit a provider from billing an employee for any amount for health care services provided for the treatment of a covered work-related injury or illness if that amount is disputed by the carrier under its utilization review program or if the amount is more than the maximum allowable payment established by these rules. The carrier shall request the employee to notify the carrier if the provider bills the employee.

### PART 14. DATA ACQUISITION

R 418.101401 Annual medical payment report.

Rule 1401. (1) Payments for medical services received by injured workers shall be reported to the workers' compensation agency on a form prescribed by the agency entitled "Annual Medical Payment Report (WC-406)." The agency shall provide instruction to the carriers and service companies regarding completion of the form. The annual medical payment report shall cover the periods January 1 through December 31 and shall include all of the following information:

(a) The total number of medical payments for health care services for medical cases, wage loss cases, and the carrier's total number of worker's compensation cases in each category during the reporting period.

(b) Medical only cases, defined as those cases where no indemnity was paid, and the total medical payments made by the carrier for those cases.

(c) Wage loss cases, defined as those cases in which wage loss or indemnity was paid, and the total medical payments made by the carrier for those cases. For the purposes of this



annual medical payment report, once wage loss benefits are paid, then the case shall always be reported as wage loss.

(d) For the purpose of the Annual Medical Payment Report (WC-406), “medical services” is defined as all reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws in this state as legal, and furnished by licensed practitioners within the scope of their practice. The report shall not include indemnity payments, travel expenses, payments for independent medical examinations, legal expenses, vocational rehabilitation, or on-site or telephonic case management expenses.

(2) The annual medical payment report (WC-406) shall be due to the agency by February 28 of each year. Form WC-406 is an online report and must be completed via the Health Care Services Online Program provided on the agency’s website, [www.michigan.gov/wca](http://www.michigan.gov/wca).

(3) A carrier, self -insured, or group shall submit required forms either directly or through a third-party vendor, to the agency at such time as the director deems appropriate. The forms required are both of the following:

- (a) Certification of a carrier's professional health care review program (form WC590).
- (b) Annual medical report (WC406).

#### PART 15. PROCEDURE CODE AND REIMBURSEMENT TABLES

R 418.101501 Tables for health care services and procedures.

Rule 1501. (1) Procedures that do not have relative values assigned are referenced in part 15 of these rules and have assigned fees developed by the workers' compensation agency through rule promulgation and shall be published as part of these rules.

(2) The agency shall provide separate from these rules a manual, tables, and charts containing all of the following on the agency’s website, [www.michigan.gov/wca](http://www.michigan.gov/wca):

- (a) Procedure codes and relative value units for the medical, surgical, and radiology services.
- (b) Reference to the ancillary services identified in Medicare's Level II codes as adopted by reference in R 418.10107.
- (c) Maximum payment ratios for hospitals.
- (d) A copy of the billing forms and instructions for completion.

R 418.101503 Laboratory procedure codes and maximum allowable payments.

Rule 1503. (1) The workers' compensation agency shall determine the maximum allowable payment for the laboratory procedure codes found in the 80000 series of the CPT code set. The rate shall be determined by multiplying the Medicare rate established for this state by 110%.

(2) The pathology procedure codes found in the 80000 series of the CPT code set have assigned relative values and shall be provided on the agency’s website at [www.michigan.gov/wca](http://www.michigan.gov/wca).

(3) The maximum allowable payments for the laboratory and pathology procedures shall be provided on the agency’s website, [www.michigan.gov/wca](http://www.michigan.gov/wca).