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 based upon information found in the Health Care Services Rules

The manual is organized as follows:

> **General Information** (Chapters 1-5) outlines the general policies and procedures applicable to all providers and payers.
>
> **Coding and Fee 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 maximum payment ratios for hospitals.
>
> **Agency Information** (Chapter 16) contains examples of forms and agency contact numbers.

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

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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 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 and modifiers are as follows:

Nurse Practitioner and Physician's Assistant	-GF	0.85

Mental health therapeutic services are reimbursed 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 maximum allowable payments for medical services are listed in this manual. Chapters 6-13 contain the policy and procedures unique to that category and the services are listed in numeric order according to CPT® coding. The manual's maximum allowable fee tables list the CPT® code, the RVU, the MAP. Follow-up days for surgical procedures and the payments for the Freestanding Surgery Outpatient Facility (FSOF) are listed in the surgery section. **Except where otherwise noted in this manual, billing instructions listed in the "Physicians' Current Procedural Terminology (CPT®)" shall apply.**

Separate fee tables will be listed for the different categories of medical services at the end of chapters 5-12. Descriptors are no longer listed with the fees; therefore, it is

imperative that both payers and providers maintain current CPT®/HCPCS publications.

In most instances, the fees will also include both a facility and non-facility site of service Maximum Allowable Payment (MAP) for practitioner reimbursement. Specific reimbursement information will be found in the headers and footers of each fee table section. The site of service on the CMS-1500 shall determine what MAP is used for practitioner reimbursement. Cost-to-charge ratio methodology will be used to reimburse all hospital services

Maximum Allowable Payment (MAP) Amounts

The maximum allowable payments in this manual are based upon the Centers for Medicare and Medicaid (CMS) resource-based relative value scale (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	**1.0216**
Practice Expense	**.9976**
Malpractice	**1.8948**

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

(Work RVU's x **1.0216**) + (Practice Expense RVU's x **.9976**) + (Malpractice RVU's x **1.8948**) = 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.** The conversion factor for the CPT® procedure codes is found in R 418.101002a of the Health Care Services rules.

Determining Payment

The MAP amounts 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 **or the provider's charge, whichever is less,** and shall not balance bill the worker (Refer to R 418.10105).

By Report (BR) Services

When a procedure code does not have an assigned fee or relative value (RVU), the procedure shall be considered by report (BR). A provider who submits a claim for 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, defined in the definition section of the Health Care Services rules, 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 the CPT® book 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 (IME's)

A carrier or employee may request an independent medical evaluation (IME). A practitioner other than the treating practitioner must do an independent medical examination. The IME is exempt from the Health Care Services Rules for cost containment and payment is determined on a contractual basis. The carrier and provider should address how diagnostic testing will be reimbursed in the contractual agreement.

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 consultation codes and paid in accord with the fees listed in the Evaluation and Management Section of this manual.

Claim Filing 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 workers' compensation, as the agency does not pay or review bills. The State of Michigan Workers' Compensation Health Care Services rules discuss this information in R 418.10113 and R 418.10901(3).

Rehabilitation Nurse or Nurse Case Managers

When a carrier assigns a nurse case-manager or a rehabilitation nurse to a worker's compensation case and the nurse accompanies the patient to physician office visits, the physician may bill RN001. The carrier will then reimburse the physician for RN001, a work-comp code specific for Michigan, in addition to the office visit, and be paid for the additional service. If the patient is seen during the global surgery period and is accompanied by the nurse case manager, procedure RN001 is payable even though the routine **non-complicated** office visit is included in the global period for the surgical procedure. The reimbursement for RN001 is $25.00.

Chapter 2

General Policy

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

Employee Responsibilities

An employee receiving an injury or illness during the course of employment must report the injury to his employer. The employer may direct care for the injured worker for the first 10 days. After 10 days from the inception of medical care for a compensable injury, **the worker may treat with a physician of his or her own choice by giving the employer the name of the physician and his or her intention to treat with the physician**. If an employee receives a medical bill for a covered work injury, the employee should submit the bill to the employer or, if known, the carrier.

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 may direct the employee to a provider of the employer's choice for the first 10 days of care for the injury or illness and **report the injury to their workers' compensation carrier.**

The insured employer must promptly file the Form 100, "Employer's Basic Report of Injury" reporting 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 (marked DB for duplicate bill) to the carrier and add a 3% late fee**.

The provider may file for an "Application for Mediation and Hearing," (104B) for unresolved claims (See Part 13 of the Rules and Chapter 4 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 contests a carrier's dispute and the case becomes contested or litigated (worker files 104A with the agency for a hearing). **The provider should then file a 104B to be added as an intervening party to the carrier/worker dispute.**

> **Note:** If the worker has not contested the carrier's denial, then the worker or his/her health insurance is responsible for services disputed as not work-related.

Carrier Responsibilities

When the carrier receives notice of an injury or illness, the carrier:

- Establishes a case record. 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 shall also investigate a case if notified by the provider with form 117 H, "Provider's Report of Claim."
- Determines compensability.
- Reviews medical bills for payment. 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 one-time self-assessed 3% late fee applied to the MAP or the provider's charges, whichever is less.**
- Notifies the provider of their decision to pay, adjust or reject a medical provider's bill on a form entitled **"The Carrier's Explanation of Benefits."**
  - The Health Care Services Division of the workers' compensation agency determines the format for this form.
  - Changes to the format may not be made without approval from HCSD.
  - A copy must be sent to the injured worker and the provider.
  - A copy of the form (WC-739 Rev. 4-07) is located in Chapter 16 and on the agency's website.
  - Due to privacy laws it is important that the worker's Social Security Number (SSN) be protected, therefore, it is only necessary to display the last 4 digits on the EOB. The carrier and provider shall maintain the worker's SSN on file, as it is a required field for any disputes or hearing requests. All agency case files continue to be identified by the SSN.

Certification of a Carrier's Professional Review Program

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, R 418.10101, Scope of the Health Care Services rules).

Applying for certification

- The carrier submits form WC-590 **"***Application for Certification of Professional Review*", including their methodology for performing professional utilization review. Certifications of the professional review are generally granted for a period of three years. If a current methodology is already on file with Health Care Services, then only the completed form WC-590 need be submitted. The carrier must sign the form. The carrier may contact the agency to see if the methodology on file is current.
- The WC-590 must be submitted 6 months prior to the expiration date of the certification (R 418.101208 (1)).
- The carrier must re-submit a signed and completed WC-590 if changes occur in their service company, review company, or if there are substantial changes in their method of review.
- Health Care Services will send a WC-591,"*Certification Of A Carrier's Professional Review Program"* to the carrier, service company and review company contacts listed on the application (WC-590) notifying the appropriate parties of approved certification.

Methodology

The carrier or their designee shall submit a current methodology detailing their professional review program. The methodology is maintained on file by Health Care Services for 3 years. Changes to this methodology must be in writing and forwarded to health care services within 30 calendar days of event.

A copy of the Carrier's Explanation of Benefits (WC-739 Rev. 4-07) must be included with submission of the methodology. According to the R 418.101001, the carrier must use a format approved by Health Care Services. This format is published in chapter 16 of this manual. The carrier must have approval from the Health Care Services division for changes to this format.

A carrier's review methodology consists of both professional and technical components. A carrier must submit information on their technical review as well as professional review.

Elements that must be included when submitting the methodology are:

- How payment and reconsideration decisions are made.
- Assurance of confidentiality of records.
- Licensure information for each licensed, registered or certified individual.
- Licensure information and medical specialty of the medical/clinical director and medical peer reviewers.

Technical Review (Part 12, R 418.101203)

Manual or computer software edits for payments based upon the rules. The carrier is

responsible for determining accuracy of coding and edits performed. The Carrier's Explanation of Benefits (WC-739 Rev. 4-07) shall detail reasons for recoding any procedure in accord with Part 13 of the rules.

Professional Review Program (Part 12, R 418.101204-R 418.101210)

Professional review is required by the rules when

- Medical costs per case exceed $20,000.
- Inpatient hospital care.
- Any case deemed appropriate by the carrier.

The carrier is responsible for a review program that determines the medical necessity and appropriateness of services. The utilization review process will look at coding accuracy and compensability issues, and may be performed with initial billing or upon requests for additional payment. Claims review is generally retrospective, as Michigan law does not mandate managed care, and is performed for purposes of reimbursement.

Licensed, registered or certified individuals with suitable expertise, in occupational injury or disease processes, perform professional review. Technicians may also perform review aspects using criteria set forth by the licensed, registered or certified individuals. The carrier may utilize peer review to support decisions made in the utilization review process when the carrier and the provider cannot mutually resolve the issues. Generally, peer review is performed by a doctor of medicine, doctor of osteopathy, chiropractic physician, or a physical therapist having the same clinical licensure as the treating provider whose services are being reviewed.

<u>Reconsiderations/Appeals</u> (Part 13 of the Rules).

- Carrier must pay a properly submitted bill in 30 days or pay the provider a one-time self-imposed 3% late fee and the notice of payment is sent on the Carrier's Explanation of Benefits (WC-739 Rev. 4-07).
- If the provider disagrees with the utilization decision or the payment is not made in accord with the rules, then the provider submits a written request for reconsideration within 60 days.
- If the carrier does not respond within 30 days to the provider's request for reconsideration or does not mutually resolve the outstanding issue, then the provider should file an "Application for Mediation and Hearing" (104B) on the current version of the original orange form, sending a copy to the carrier.

<u>Annual Medical Payment Report</u>

A carrier is also required to submit an "**Annual Medical Payment Report" (WC-406)** to health care services, documenting the number of medical only cases, the number of wage loss cases and the total dollars spent for health care for those cases.

All entities with a NAIC or a self insured number must file an Annual Medical Payment Report per 418.101401(1).

The reporting period will begin each year on January 1 and end each year on December 31. A copy of the form is located in Chapter 16. The Annual Medical Payment Report is due February 28 for the preceding calendar year and should include:

- Carrier Information.
- Signature, address, telephone number and e-mail address of person responsible for completion of the form. And alternate contact persons name and contact information.
- The number of Medical-only Cases and the total dollars spent for medical services in that year. Medical-only is defined as those cases where no indemnity was paid.

  Note: Refer to the definition of a case in the Health Care Services Rules. Each case will generally have multiple bills. Do not count each bill as a case.

- The number of Wage-loss/Indemnity Cases and the total dollars spent for medical services in that year. Wage-loss is defined as those cases in which the carrier paid wage-loss replacement. For the purposes of this Annual Medical Payment Report, once wage-loss benefits are paid, the case will always be reported as wage-loss.
- **Report only medical expenses**. Do not include payments for:
  - Indemnity
  - Mileage reimbursements
  - Vocational rehabilitation
  - Rehabilitation case management
  - Independent medical evaluation(s)

Service Companies and Insurance Companies will report as follows:

- **SERVICE COMPANIES:** Individual self insured employers submit one report for each self insured client represented, noting the Self Insured ID number assigned to that employer. This includes tail claims also if you are no longer the current active service company.

  When a service company is hired by an insurance company to administer claims, the annual medical payment data for that insurance company must be forwarded to the insurance company. The insurance company will be responsible for compiling the data and submitting one consolidated report to the Agency.

- **GROUP SELF INSURERS:** Submit one consolidated report for all employer members of the group self insured client represented, noting the Self Insured ID number assigned to the group.

- **SELF-ADMINISTERED EMPLOYERS OR SELF-ADMINISTERED GROUP FUNDS:** Submit their own reports.

- **INSURANCE COMPANIES:** Each insurance company must submit the Annual Medical Payment Report with their individual NAIC number for proper identification. They may not be combined with any other insurance company. If the insurance company is contracting with a servicing agent or a third party administrator, the insurance company is responsible for reporting this data to the Agency on their Annual Medical Payment Report.

*****If no longer doing business in the State of Michigan you must complete the annual medical report and report all tail claims. Note, on form WC406 date company discontinued doing business in Michigan.**

Required Documentation

Providers are required to submit documentation for the following: (See R 418.10901)

- 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.
- The x-ray report is required when the professional component of an x-ray is billed.
- The anesthesia record for anesthesia services.
- A functional capacity or work evaluation.
- When billing a By Report (BR) service, a description of the service is required.
- Whenever a modifier is used to describe unusual circumstances.
- When the procedure code descriptor states, “includes a written report”.
- The FSOF must include an invoice with implants billed.

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

- The patient’s history and physical examination appropriate to the level of service indicated by the presenting injury or illness.
- Operative reports, test results and consultation reports.
- 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).

- 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, Rule 114 and Rule 109). The Health Care Services rules (R 418.10118) apply only to medical records in the possession of a health care provider relating to the specific work related condition, treatment and request for payment of that treatment. Rule 118 does not pertain to medical records requested by a subpoena that are part of litigation.

> **Note:** Practitioners billing for medical services provided to an injured worker are required by the Health Care rules (R 418.10901) to submit a copy of certain medical records at no charge with the medical bill.

Practitioners are entitled to charge for the cost of copying and mailing records when duplicate copies or additional records, not required by the Health Care rules, are requested. **Only those records for a specific date of injury are covered under the Health Care Services rules**. Those records are reimbursed at 45 cents 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:

Each 15-minute increment	$2.50

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 party requesting the records is responsible for paying the copying charge.

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

> **Note:** For the purposes of workers' compensation, the Health Care Services rules supersede Act No. 47 that went into effect on April 1, 2004.

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 section contains billing information specific to the category of services listed in that section.

Billing Information

Providers must submit charges to the carrier on the appropriate health insurance claim form. Documentation required by the rules must be legible. A carrier must pay only licensed providers and facilities. 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 **or the provider's charge, whichever is less,** 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:

- CMS-1500 (version 08/05) claim form for practitioner billing.
- UB-04 claim form to bill for facility and home health services.
- Universal pharmacy claim form or an invoice for billing outpatient pharmacy services.
- American Dental claim form for dental services.

Note: A hospital owned occupational or industrial clinic is considered a practitioner service.

If the carrier or employer makes the worker's appointment and the employer or carrier fails to cancel the appointment within 72 hours, the provider may bill for a missed appointment (**e.g., IME or confirmatory consult**) using procedure code 99199.

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.

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

- The amount is disputed by utilization review.
- That amount exceeds the maximum allowable payment.

When a balance(s) exist due to utilization review, the provider may send a request for **reconsideration to the carrier,** and if unresolved, file a request for mediation (WC-104B) except when the MAP has been paid by the carrier.

Procedure Codes

Procedure codes from *Physicians' Current Procedural Terminology (CPT®)* and *Medicare's National Level II Codes (HCPCS)* as adopted by reference in the Health Care Services rules, R 418.10107, 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 fee tables contained in this manual. Services not listed in the schedule will be considered as "by report" (BR).

Procedure codes and billing instructions are adopted from *CPT®*. The carrier, based upon their utilization review using consistent medical standards, determines reimbursement. A carrier is only required to reimburse necessary and reasonable medical services causally related to the work injury or illness.

Administered, 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 and identified with CPT® 99070 or the appropriate J Code from HCPCS, and the NDC number. The office notes must identify the drug administered. A therapeutic injection 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 minus 10 %. In addition, a dispense fee is allowed. 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 reimbursement is $5.50. **WC700-B** is billed to describe the dispense fee for each **brand** name prescription drug and reimbursement is $3.50. 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 the appropriate HCPCS code when available. If a HCPCS code does not adequately describe the supply, then 99070 may be used. A report or office notes documenting the service must be attached to the bill. Supplies are reimbursed at the DME/Supply fee schedule (based on Medicare plus 5%).

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 the carrier gives such direction, those providers are not bound by the Health Care Services rules.

- 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 CMS-1500.

The following apply to pharmacies, offices and clinics dispensing prescription drugs:

- When a generic drug exists, the generic drug shall be dispensed. When the generic drug has been utilized and found to be ineffective or has caused adverse effects, the physician may write "Dispense as Written" (DAW). When a physician writes "Dispense as Written", the physician shall document the medical necessity for the brand name drug in the record.
- The reimbursement for prescription drugs is the average wholesale price (AWP) minus 10%. In addition, a **$5.50 dispense fee** for each **generic** prescription drug will be paid when billed with **WC700-G** and a **$3.50 dispense fee** will be paid for each brand name prescription drug when billed with **WC700-B**. **Not more than one dispense fee shall be paid for *each* prescription drug every 10 days**.

- **A bill for a prescription drug shall include**:

    1. Name of the drug and the manufacturer's name.
    2. Strength of the drug.
    3. Quantity and the dosage of the drug.
    4. Name and address of the pharmacy or health care organization.
    5. Prescription number when dispensed by a pharmacy.
    6. Date dispensed.
    7. Prescriber of the medication.
    8. Patient name, address and social security number.
    9. National drug code as listed in Red Book.

Fees for supplies and durable medical equipment are based upon the Medicare fees plus 5% (R 418.10913 and R 418.10003b).

R 418.101504 Rescinded. When a valid L-code does not list a set fee, the procedure is considered by report (BR).

<u>Modifiers</u>
A modifier is a two-digit number added to a CPT® procedure code to explain a specific set of circumstances. A two-letter 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, a self-insured employer or self-insured group fund, or one of the funds specified in the Act. When a provider is unable to get **carrier information** from the employer, contact the Employer Compliance division at **(517) 322-1885** with the following information:

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

A provider can also obtain carrier information from the agency website: www.michigan.gov/wca and clicking on the insurance coverage tab at the top of the page and entering the employer information. Carrier information found on this page reflects ***current*** coverage only**.** Dates of injury prior to the date of look up may be identified with different carrier coverage. Please call (517) 322-1885 to verify coverage for prior dates of injury**.**

Collecting Medical Fees

Health care services does not review claims for payment or reimburse medical providers. The carrier (See definition of carrier above) is responsible for claims management and payment of medical services as well as wage-loss benefits. 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 laws allow.

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. Payment will be made only for actual services rendered for the covered work injury or illness.

Services Rendered by Providers Outside the State of Michigan

When practitioners or facilities in states other than Michigan render services for Michigan workers, the provider may or may not accept the 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 fees or reimburse the facility according to the laws of the state where the facility is located. 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

Michigan Workers' Compensation Health Care Services rules apply only to Michigan workers. A federal employee or an employee injured in another state and 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.

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, or

the provider's charge, whichever is less, as 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. Licensed, registered or certified health care professionals must perform utilization review, 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 medical claims for compensability and determining the services are necessary and reasonable. The carrier is required to perform professional review of the medical services whenever payments on a case exceed $20,000.00, 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 (WC-739) 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 subsequent request for 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.
- 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.

Note: Providers can reduce the frequency of services being re-coded by following guidelines within the CPT® book for correct coding and guidelines found in the Health Care Services rules.

Determining Payment for "By Report" (BR) Services

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 agency."

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 is payable. Generally when a provider sees a patient twice in one day for necessary services, the values 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.

Total Procedures Billed Separately

When two separate providers are submitting separate claims for certain diagnostic procedures (neurological testing, radiology and pathology procedures, etc.) the services are divided into professional and technical portions. When this occurs, the carrier will pay 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 Explanation of Benefits (EOB) Form (WC-739 Rev. 4-07)

The EOB form 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, what information is needed and the time frame that this is to be done.
- 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(s) 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 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 with workers' compensation by submitting the "Application for Mediation and Hearing" form (WC-104B). A carrier may request a hearing to recover overpayments (refer to Rule 120); however, providers of health care services most frequently request hearings 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 customer service at (888) 396-5041 selecting #1 on each menu, or (517) 322-1980.

A Provider's Reasons for Requesting Mediation Hearings:

- No response to the provider's bill.
- Payment dispute unresolved though 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 agency, the worker's health insurance is responsible for

the health services. A worker should not be turned over to collections if there is a pending workers' compensation claim that has not been resolved by the magistrate.

The requesting party submits the *current*, original (orange) form to the agency and sends a copy to the carrier or provider as appropriate. **The 104B form is obtained from the Workers' Compensation Agency or is available for download from the Agency website. When you choose to download the 104B you must print both sides of the form and use the same orange paper according to Agency format.** Documentation should **not** be sent with the application.

Ordering Forms

Workers' Compensation forms, including 104B forms, are obtained from the agency. You may order forms by one of the following methods:

- Mail request to Claims Division, WCA, PO Box 30016, Lansing MI 48909.
- Email to wcinfo@michigan.gov
- Request by Fax (517) 322-1808.
- Call (888) 396-5041 and follow the prompts for forms.

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

Chapter 5

Claim Form Completion

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. For reference, the CMS website is located at http://cms.hhs.gov/home/medicare.asp.

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 CMS-1500 Form for Practitioner Billing

The CMS-1500 (Formerly known as 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. In August 2007, providers were required by all other payers to use the CMS-1500 (08/05) version of the CMS 1500, therefore this chapter will include instructions for the CMS-1500 (08/05) version.

Note: The National Provider Identification (NPI) number is required to be on workers' compensation bills beginning on the effective date of the 2008 HCS rules.

Note: Radiologists (billing technical services only), pathologists, and ambulance services are not required to enter a diagnostic code.

The following information outlines what billing information is to be included and where it is to be placed when billing on a CMS-1500 (08-05) claim form. **SOME OF THE REQUIREMENTS HAVE CHANGED FROM 2007 – BILLS MUST CONTAIN THE INFORMATION OUTLINED BELOW BEGINNING ON THE EFFECTIVE DATE OF THE 2008 HCS RULES.**

CMS-1500 (08-05) Claim Form Elements 1 through 33

1. Mark other.
1a. Carrier Claim Number (After carrier assigns).
2. Name of the patient.
3. Patient's sex and date of birth.
4. Name of the patient.
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.
10a-c. Mark the appropriate boxes.
10d. Patient’s social security number.
11. Omit.
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.
17 b. Omit.
18. Date if applicable.
19. Reserved for local use. (This area may be used to report NDC codes or provide description of items billed with 99070, the unlisted drug and supply code that cannot be accommodated in 24 1-6).
20. Mark appropriate box.
21. Diagnostic numeric or alpha code.
22. Omit.
23. Omit.
24. Each of the six lines is split length-wise and is shaded on the top portion for reporting supplemental information.
24a. Date for each service, "from/to" dates may be utilized.
24b. Place of service code.
24c. Omit.
24d. Enter the procedure code and modifier if appropriate. Attach documentation to explain unusual circumstances.
24e. Related diagnosis number(s) 1, 2, 3, 4 as appropriate.
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.
24i. Omit.
24j. 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 (either the original bill date or the duplicate bill date).
32. Complete if applicable.
32.a. NPI of Service facility if appropriate.
32.b. Reporting of other ID numbers.
33. Billing Provider's name, license, registration or certification number, address, zip code, and telephone number.
33a. Billing Provider's NPI number.

Place of Service Codes: Note: Place-of-Service codes (element 24b) are located in the front of the CPT book. A complete listing of the following codes can be found at the CMS Web site.

11 - Office or clinic.
12 - Patient home.
21 - Inpatient hospital.
22 - Outpatient hospital.
23 - Emergency room - hospital.
24 - Ambulatory Surgical Center (Free-Standing Outpatient Surgical Center).
31 - Skilled nursing facility.
32 - Nursing home/nursing facility.
33 - Custodial care Facility.
34 - Hospice.
41 - Ambulance (land).
42 - Ambulance (air or water).
51 - Inpatient psychiatric facility.
52 - Day care facility (psychiatric facility/part hospital).
53 - Community mental health.
56 - Psychiatric residential facility.
81 - Independent laboratory.
99 - Other locations (other place of service).

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.
1. Patient Name, First, M.I., Last
2. Mark "self."
3. Enter the sex of the patient.
4. Enter patient's birth date (MMDDYYYY).
5. Omit.
6. Enter the patient's complete mailing address.
7. Enter the patient's social security number.
8. Omit.
9. Enter the employer's name.
10. Enter the employer's complete mailing address.
11. Omit.
12-a. Omit.
12-b. Omit.
13. Omit.
14-a. Omit.
14-b. Omit.
14-c. Omit.
15. Omit.
16. Enter the name of the dentist or dental organization.
17. Enter the complete address of the dentist or the dental-organization.
18. Enter the social security number or FEIN for the dental provider.
19. Enter the dentist's license number.
20. Enter the dentist's telephone number.
21. Enter the first visit for the current series of treatment.
22. Mark appropriate box for place of treatment.
23. Indicate if x-rays are enclosed and how many.
24-30. Mark appropriate boxes. Enter the date of injury in Item 24.
31. Enter the tooth number, a description of the service, and the date of service, the procedure number, and the fee.
32. Indicate with an "x" any missing teeth. Add remarks for unusual services. Include any dental disorders that existed before the date of injury.

Facility Billing

Licensed facilities are to submit facility charges on the UB-04 claim form in accord with the billing instructions provided in the current Official UB-04 Data Specifications Manual published by the American Hospital Association – National Uniform Billing Committee. The workers' compensation carrier is responsible for ensuring that the form is properly

completed prior to payment. **A copy of the UB-04 billing manual can be obtained by contacting:**

American Hospital Association
National Uniform Billing Committee – UB-04
P.O. Box 92247
Chicago, IL 60675-2247
(312) 422-3390

Hospitals must submit charges for practitioner services on the current CMS-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 clinic.

Chapter 6

Evaluation and Management

This section stipulates only those policies and procedures that are unique to Evaluation and Management (E/M) Services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

For the purposes of workers' compensation, a provider may bill a **new patient** evaluation and management service for **each new date of injury**. Additionally, a new patient visit may also be billed every three years in accordance with CMS.

Levels of E/M Services

E/M codes are grouped into three categories: office visits, hospital visits, and consultations. For complete instructions on identifying and billing E/M services, refer to the Evaluation and Management Services Guidelines of the CPT® Manual**.**

E/M service descriptors have 7 components. These components are: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time.

> An **assessment of range of motion shall be included in the E/M service.** Range of motion shall not be paid as a separate procedure unless the procedure is medically necessary and appropriate for the patient's diagnosis and condition.
>
> The **level of an office visit (E/M)** is not guaranteed and may change from session to session. The level of service billed must be consistent with the type of presenting complaint and supported by documentation in the record (example: a minor contusion of a finger would not appropriately be billed with a complex level of service, such as level 4 or 5).
>
> An ice pack/hot pack is not payable as a separate service when performed solely with an evaluation and management service.

Procedure codes 99450-99456 may not be used to describe an E/M service. The practitioner should use codes 99201-99350 to describe services for an injured worker. In addition, code 99499 may not be used to describe an office visit or hospital service when documentation supports use of 99201-99350.

Consultations

The June 2006, Volume 16/Issue 6 published revision regarding consultations. According to CPT® guidelines, a "consultation" initiated by a patient and/or family, and not requested by a physician, is not reported using the consultation codes but may be reported using the office visit codes as appropriate. If the patient or family seeks the

confirmatory opinion in the office setting, 99201-99215 should be reported. Confirmatory consultation codes were considered redundant and were deleted in 2006.

A coding tip listed in CPT® Assistant indicates when the consultation is mandated by a third-party payer (i.e. Workers' Compensation Carrier) modifier -32, *Mandated services,* should be appended to the consultation code.

Office Visit with a Surgical Procedure

The CPT® Surgery Guidelines indicate that the global surgery package includes office visits *subsequent* to the decision for surgery, therefore, an office visit to determine the need for surgery is payable. **When a minor surgery (including laceration repair) is performed on the same day as the initial examination, the office visit is payable.** When billing the E/M service, modifier –25 is added denoting that a separate identifiable E/M service was performed on the same date.

Office Visits for follow-up of a Surgical Procedure

When a service listed in the surgical section of the fee schedule is assigned a number of follow-up days (FUD), no payment will be made for office visits or hospital visits for *typical, routine,* ***non-complicated*** normal follow-up post-operative surgical care. Physicians may, however, charge for supplies (i.e. dressings, braces) furnished in the office. If the length of follow-up care goes beyond the number of follow-up days indicated, the physician will be allowed to charge for office/hospital visits.

Office Visit With Ongoing Physical Treatment

An E/M service and Physical Therapy are considered separately identifiable services. An office visit performed solely to evaluate the patient's progress in physical therapy is not payable, as evaluation of ongoing physical medicine services is included in the 97000 series of codes.

If the E/M service is separately identifiable and performed on the same day as a physical medicine service, then modifier –25 shall be used and the supporting documentation shall be furnished.

The E/M service may also be appropriately performed during the course of the physical medicine treatment but on a separate day; then in that case modifier –25 is not used. With ongoing physical therapy, an E/M service **is appropriately billed** when evaluating return-to-work issues, changes in restrictions, medication changes, or other compensable issues not related to the evaluation of the physical medicine services.

If there is a documented change in signs and symptoms, then the provider must re-evaluate the patient and develop a new treatment plan, and in this case, the E/M service is appropriately billed with modifier –25 to indicate that the re-evaluation is a separately identifiable service from the on-going physical medicine services.

Documentation shall be furnished with the bill.

After-Hour Services

Add-on procedure codes are only payable for office services when the practitioner is providing office services after normal office hours. These codes should not be reimbursed when the services occur during the provider's normal business hours (example: hospital ER or a 24-hour clinic).

Office Visits and Administration of Injectable Medication

An injection administration code for the therapeutic injectable medication is not payable as a separate procedure when billed with an E/M service. The medication administered in the therapeutic injection shall be billed with procedure code 99070 or the appropriate J-code and identified with the NDC code. The drug is reimbursed at the average wholesale price of the drug (AWP). If an E/M service is not billed, then the administration codes may be billed in addition to the drug.

Office Visits and Administration of Immunizations

An office visit may be billed and paid separately when an immunization procedure code is billed. Immunizations are billed with corresponding CPT® procedure codes for administration under the medicine section. Follow specific CPT® instructions for when the administration can be billed separately. An example of an immunization is tetanus toxoid vaccine. The immunization vaccines are reimbursed at the average wholesale price of the drug minus 10%.

Handling and Conveyance of Specimens

When a specimen is **obtained and sent** to an outside laboratory the provider may add 99000 to the bill to describe the handling/conveyance of the specimen. The carrier shall reimburse $5.00 for this service in addition to the evaluation and management service.

Services Occurring "After Hours"

When an office service occurs after a provider's *normal* business hours, procedure codes 99050-99058 may be billed. Payment shall not be made for these codes when the service occurs during the provider's normal hours of business (e.g., emergency room or clinics that are open 16-24 hours of the day).

Miscellaneous Procedures

The following table outlines fees that are determined by the Agency.

99000			Handling or conveyance of specimen.		$5.00
99050			After hour office service Monday Friday (R 418.10202).		$12.00
99052			Services between 10:00pm and 8:00am.		$5.00
99054			Weekend, holiday after hour office service.		$12.00
99199			Carrier arranged missed appointment. (R 418.10112).		BR
99199		-32	Carrier or requested report, per page (R 418.10114).		$25.00
WC700		-G	Prescription drug dispense fee (R 912 & 101003a) – Generic.		$5.50
WC700		-B	Prescription drug dispense fee (R 912 & 101003a) – Brand Name.		$3.50
99455		-32	Carrier requested visit for job evaluation (R 418.10404).		$70.00
RN001			Rehabilitation or case manager visit (R 418.10121).		$25.00

Supplies and Material

Supplies and materials provided by the physician or health care organization over and above those usually included with the office visit are payable by the carrier. When supplies are separately billed the provider shall use the appropriate HCPCS code to describe the service and shall be reimbursed according to the fees established by R 418.10913 and R 418.1003b.

The following are *examples* of supplies usually included with the office visit:

Sterile or non-sterile dressings and tape	Antiseptic ointments, solutions & alcohol wipes	Gloves & cotton-tipped applicators
Butterfly dressings Cold or hot compress	Minor educational supplies	Syringes, medicine cups & needles

Chapter 7

Anesthesia

This section stipulates only those policies and procedures that are unique to anesthesia services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

General Information and Overview

Payment for an anesthesia service includes all usual pre-operative and post-operative visits, the anesthesia care during the procedure, and the administration of fluids and/or blood incidental to the anesthesia or surgery and usual monitoring procedures. Specialized forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included in the anesthesia base. **The anesthesia procedure code billed on the CMS-1500 reports the base units for the procedure.** Base units are listed in "Medicare RBRVS: The Physicians' Guide," as adopted by reference in R 418.10107.

To report regional or general anesthesia provided by the surgeon performing the surgical procedure see modifier -47, Anesthesia by Surgeon, discussed in this chapter or in the CPT® manual. When anesthesia is provided by the surgeon only the base units shall be paid.

Time Reporting

Anesthesia time units are equivalent to 15-minute intervals for the actual administration of the anesthesia and 30-minute intervals for supervision of a certified registered nurse anesthetist (CRNA). Not less than the equivalent of one (15) minute unit for administration or one (30) minute unit for supervision shall be paid.

Time is reported by placing the total number of minutes for the anesthesia service in the days or units column on the CMS-1500 claim form (element 24g on the CMS-1500 (08-05).

Anesthesia time begins when the anesthesiologist (or CRNA) begins to prepare the patient for the induction of anesthesia in the operating room, or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance.

Determining Anesthesia Payment

Anesthesia services are reimbursed based upon total base units + total time units. Anesthesia services may be performed and billed by an anesthesiologist, a certified registered nurse anesthetist (CRNA), or both. The base units for a procedure are paid only once for the anesthesia service. Whenever multiple surgical procedures are performed, the anesthesia procedure with the greatest number of base units shall be billed to describe the anesthesia base services.

Anesthesia services are submitted on the CMS-1500 using the anesthesia procedure code and a **modifier to identify the service provider**. A copy of the anesthesia record must be included. The carrier will reimburse as follows:

-AA is used when the anesthesiologist administers the anesthesia. The provider is paid $42.00 for each base unit billed, plus $2.80 for each minute of anesthesia administered and billed.

-QK is used when the anesthesiologist is supervising a CRNA. The provider is paid $42.00 for each base unit billed, plus $1.40 for each minute of supervision.

-QX is used to describe CRNA services under the supervision of the anesthesiologist. The CRNA is paid $2.80 for each minute of anesthesia administered and billed.

-QZ is used to describe CRNA services performed without supervision of an anesthesiologist. The CRNA in this instance would be paid the same as the anesthesiologist billing with modifier -AA (base +$2.80 per minute).

Note: The CRNA is generally supervised in most hospitals by an anesthesiologist. **Modifier -QZ cannot be billed on the same date as Modifier -AA or Modifier -QK for an anesthesia service.**

If the anesthesiologist employs the CRNA, the anesthesia service is billed on 2 lines of the CMS-1500. The anesthesia procedure code is billed with modifier -QK designating the anesthesiologist service and again on a second line with modifier -QX to represent the CRNA service.

Physical Risk Modifiers and Emergency Anesthesia

When a provider bills physical status modifiers, documentation shall be included with the bill to support the additional risk factors. The physical status modifiers are assigned unit values. When appropriate, the unit value would be added to the base units and be paid at $42.00 per unit. The values assigned are:

P1	A normal healthy patient.	0
P2	A patient with mild systemic disease.	0
P3	A patient with severe systemic disease.	1
P4	A patient with severe systemic disease that is a constant threat to life.	2
P5	A moribund patient who is expected not to survive without the operation.	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes.	0

Procedure code 99140 would be billed as an add-on procedure when an emergency condition complicates anesthesia. Documentation supporting the emergency must be included with the bill.

- Refer to the Health Care Services Rules, R 418.10108 (n) for a definition of emergency condition.
- On-call coverage does not meet criteria for billing 99140.

Chapter 8

Surgery

This section stipulates the policies and procedures that are unique to surgery.

General

The schedule of maximum allowable payment (MAP) amounts for surgery lists the following:

- CPT® code and modifier.
- RVU.
- MAP amount for facility and non-facility site of service.
- Global Days (follow-up days).
- Assistant Surgeon (with key in the header that determines if an assist is permissible). See Surgical Assistant section below.
- Free Standing Surgical Outpatient Facility (FSOF) MAP.

A claim for a surgical procedure (procedure codes 10021-69990) is considered incomplete unless accompanied by an operative report. The **office notes** documenting a surgical procedure performed are also considered the operative report for those surgical procedures performed in the office setting.

Follow-up Care

During the follow-up period no payment will be made for hospital or office visits for *typical, non-complicated* post-operative follow-up care. Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported.

Global Procedure (Package)

The payment for surgical procedures is based upon a global package concept. Global payment requires that the service(s) performed be identified and billed using the fewest possible CPT® codes ("unbundling" is not allowed).

The global surgical procedure includes:

- The immediate preoperative care. **A consultation or an evaluation, even if performed on the day of surgery, to evaluate the need for surgery is not considered part of the global procedure and should be reported separately.**
- Local anesthesia, such as infiltration, digital, or topical anesthesia.
- The surgical procedure and application of the initial dressing, cast, or splint,

writing post-operative orders, dictation of the operative report are included.

- Routine, normal, uncomplicated follow-up care (follow-up days/FUD noted in the manual).

  Note: When office visits are required to treat complications or other conditions or injuries in the follow-up period for the surgical procedure, documentation must be submitted with the charges to support medical necessity for the office visit. The E/M code billed is modified with -25.

- Suture removal by the same practitioner or health care organization.
- The day after the service is rendered is considered Day 1 of the follow-up period.

Carrier or Employer requested visits during the global period.

When a **carrier or an employer requests** a visit during the global period for the purpose of changing or modifying a work restriction or to evaluate for a different job, the carrier will prior authorize the visit and instruct the provider to bill with 99455-32. The carrier will pay the additional visit at $70.00. If the employer requests the visit, the employer should obtain the prior authorization number from the carrier.

Anesthesia by Surgeon

Regional anesthesia provided by the surgeon is reported by adding modifier –47 to the basic service. The anesthesia code 01995 would be placed on a separate line of the CMS-1500 claim form to describe the regional anesthesia and the surgeon is paid only the **base units** for the procedure.

Note: Payment is not made when infiltration, digital, or topical anesthesia is provided (local anesthesia is included in the global package).

Surgical Supplies

Supplies and materials provided by the physician (e.g., sterile trays/drugs), over and above those usually included with the office visit or other services rendered may be listed separately. List drugs, trays, supplies, and materials provided, identified by using the appropriate HCPCS code.

Multiple Procedures (More than one procedure performed at a single operative session)

When the same practitioner performs multiple procedures at a single operative session, the major primary procedure (procedure with highest RVU) is billed with the applicable CPT® code and is paid at 100% of the MAP amount. The additional or lesser procedure(s) must be billed using modifier -51. Payment for the additional procedure(s) will be made at 50% of the listed MAP amount. See Appendix E of current CPT® for codes that are exempt from the application of modifier -51.

Exceptions:

- When the CPT® designates **"add-on procedure" or "each additional procedure"** no modifier is appended and reimbursement is **100% of the MAP,** or the provider's usual and customary charge, whichever is less.
- When multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body is reimbursed at 100% of the MAP amount, and the remaining procedures for each part are identified with modifier -51 and paid at 50% of the MAP amount.

Separate Procedures

A procedure designated as **"separate procedure"** in the descriptor is commonly performed as a component of a larger procedure and, as such, must not be paid as a separate service. However, when a "separate procedure" is performed independently of, and not immediately related to other services, it may be billed and paid.

Bilateral Procedures

When a CPT® code for a bilateral procedure is not available, report the CPT® code for the primary procedure on **one line** of the claim form and append with **modifier -50**. Reimbursement shall be **150% of the MAP** amount or the provider's usual and customary charge, whichever is less.

<u>Surgical Assistant (Technical Assistant)</u>

A technical surgical assistant fee may only be billed for designated surgical procedures found in the surgical fee schedule in this section. In the column Asst Surg, found on the surgery fee table, will be numbers denoting payment restrictions or allowances as follows:

- 0 = Assistant surgeon is paid with documentation of medical necessity.
- 1 = Assistant surgeon may not be paid.
- 2 = Assistant surgeon is payable.
- 9 = Concept of assistant surgeon does not apply for this procedure.

When billing for an assistant surgeon service (Technical Assistant), the **operative report documenting the assistant surgeon shall be included with the bill.** An assistant surgeon's service may be billed by:

- A doctor of dental surgery.
- A doctor of podiatry.
- A doctor of osteopathy.
- A doctor of medicine.
- A physician's assistant.

- A nurse with a specialty certification issued by the state (nurse practitioner or nurse midwife).

The carrier shall reimburse either 13% or 20% depending on the practitioner type as noted in the following section.

Physician Surgical Assistant

Append the procedure with modifier -80 and bill the usual and customary charge for the primary procedure. Reimbursement will be **20% of the MAP** or the provider's charge, whichever is less.

Certified Physician's Assistant or Nurse Practitioner or Midwife as Surgical Assistant

Append the procedure with modifier -81. Reimbursement will be **13% of the MAP,** or the practitioner's usual and customary charge, whichever is less.

> **Note:** When an office is billing for both the primary surgeon and the technical surgical assistant, two (2) lines are used on the CMS-1500.

Co-Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a *single* reportable procedure, each surgeon should report their distinct operative work by adding Modifier -62 to the single definitive procedure. Each surgeon should report the co-surgery once using the same procedure. If additional procedure(s), including add-on procedure(s), are performed during the same surgical session, separate code(s) may be reported without modifier -62.

> **Note:** If a co-surgeon acts as an assistant for the remaining procedures, then modifier -80 may be appended as appropriate.

Multiplying the MAP amount for the surgical procedure, times 125%, and then dividing the result by 2 determines payment. **Each co-surgeon** receives half of the resulting amount or **62.5% of the MAP amount**.

Surgical Team

Under some circumstances highly complex procedures are carried out under the "surgical team" concept. Each participating physician would report the basic procedure with the addition of modifier -66.

<u>Wound Repair and Suture Removal</u>

Payment for wound repair includes the routine debridement, materials normally required to perform the procedure and suture removal. An E/M service that determines the need for surgery is payable. In the event that another physician, not associated with the initial

physician, performs suture removal, that physician may be paid for the office visit at the appropriate level of service and list the HCPCS code for the suture removal kit.

> **Note:** The following policies for description of wound repairs listed below are noted in the CPT® manual.

Wound repairs are classified as Simple, Intermediate, or Complex and defined as follows:

- **Simple Repair:** When a wound involves only the skin and/or superficial tissues and requires simple suturing or use of adhesive. (When closure is done with adhesive strips, the surgical procedure is not charged and *only* the appropriate office visit is paid).

- **Intermediate Repair:** When a wound involves deeper layers and requires layer closure.

- **Complex Repair:** When a wound is more complicated and requires more than layered closure.

The repaired wound(s) should be measured and recorded in centimeters, indicating when the shape is curved, angular, or stellate.

When multiple wounds of the same classification (see above) are repaired, add together the lengths of those wounds and report them as a single repair. When multiple wounds of more than one classification are repaired, list the more complicated as the primary procedure, and report the less complicated as the secondary procedure by listing it separately and adding modifier -51.

Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.

When there is involvement of nerves, blood vessels, and tendons, the repair is reported under the appropriate system (nervous, cardiovascular, musculoskeletal, etc.). The repair of these associated wounds is included in the primary procedure, unless it qualifies as a complex wound, in which case modifier -51 applies.

<u>Burns, Local Treatment</u>

Procedure code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of the burned surface(s) is required.

Procedure codes 16020-16030 must be used only when billing for treatment of second and third degree burns.

> **Note:** If no burn treatment is done, then the appropriate E/M code should be used to describe the service.

Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately using CPT® code 11000-11044.

In order to accurately identify the proper CPT® code (codes 16000-16030) and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified in the proper section on the billing form. Percentage of body surface burned is defined as follows:

- **Small:** less than 5 percent total body surface area.
- **Medium:** 5-10 percent total body surface area (e.g., whole face or whole extremity).
- **Large:** greater than 10 percent total body surface area (e.g., more than one extremity).

<u>Musculoskeletal System</u>

Application of Casts and Strapping

Cast and strapping services (CPT® codes 29000-29799) may be billed and paid when the cast or strapping is a replacement procedure used during or after the follow-up care, or when the cast or strapping is an initial treatment service performed without a restorative procedure to stabilize or protect a fracture, injury or dislocation and/or to afford comfort to a patient. (CPT® Assistant Volume 6, Issue 2, February 1996 discusses when the casting codes are appropriately used).

The payment for a cast/strapping code includes the application and the removal of the cast, splint, or strapping. Casting supplies may be billed in addition to the procedure using 99070 or the appropriate HCPCS code.

Fracture Care

Fracture care provided during an initial visit must be billed under the appropriate CPT® fracture code regardless of whether the fracture is open or closed. Payment for fracture care includes the procedure and the application and removal of the first cast or traction device. Replacement casts provided during follow-up visits must be billed using the appropriate CPT® replacement casting and strapping codes (procedure codes 29000-29590). When follow-up days are indicated for the surgical procedure, payment may be made for replacement casts, but not for routine follow-up visits during the follow-up period. If no follow-up days are indicated, office visits may be billed and paid as appropriate.

Diagnostic or Therapeutic Nerve Blocks

A nerve block may be performed either for diagnostic or therapeutic purposes. The provider will select the appropriate procedure code from the CPT® book and bill as a surgical procedure.

Microsurgical Procedures

The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. **Code 69990 for microsurgery is listed separately in addition to the code for the primary procedure and is reported without modifier -51.** Do not report code 69990 in addition to procedures where the use of the operating microscope is an inclusive component or when the magnifying loupes have been used for visual correction. Refer to the CPT® manual for complete listing of codes where the operating microscope is considered an inclusive component of the primary procedure.

Chapter 9

Radiology

This section stipulates only those policies and procedures that are unique to radiology services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

General Information

Radiology services include diagnostic radiology (diagnostic imaging, diagnostic ultrasound, and nuclear medicine). Radiology services are comprised of a **professional component and a technical component.** The professional component is the physician's interpretation of the procedure, and the technical component is the equipment, supplies, and technician's services used to perform the procedure. The fee schedule lists Maximum Allowable Payments (MAP) for both the professional (-26) and the technical (-TC) components.

When a radiology service is performed in the office setting, the complete procedure is billed using the radiology procedure code without a modifier. There is no separate professional component billed by a radiologist. The office notes document the treating physician's interpretation. The office is not required to send in a radiology report when billing x-rays in the office setting.

When a radiology service is performed in a hospital setting, the facility bill shall identify the service using the appropriate CPT® code (no modifier required). The hospital is reimbursed by the cost-to-charge ratio methodology. The radiologist will bill the professional component identifying the service with the appropriate code and modifier -26.

Payment Reductions for Multiple Procedures

Nuclear Medicine Procedures

Multiple procedure payment reduction policy shall be applied when billing more than one of the following nuclear medicine procedure codes: 78802, 78803, 78806 and 78807. Modifier -51 shall be appended when more than one procedure is performed in the same setting (office, clinic or a free-standing radiology office). The payment for the complete, technical and professional service shall be reduced by 50%.

When performed in the hospital setting, this multiple procedure payment reduction does not apply as hospitals are reimbursed by cost-to-charge methodology.

Multiple Procedures within Families (Groups of Contiguous Body Parts)

When two or more radiology procedures from a given "family" are performed in a free-standing radiology office, a non-hospital facility or a physician's office or clinic, the multiple payment reduction policy shall apply to the **technical component** only. The primary procedure, identified by the procedure code with the highest relative value, shall be paid at 100% of the maximum allowable payment (MAP). If the providers charge is less than the MAP, the service shall be paid at the providers charge.

When multiple diagnostic imaging procedures are performed on contiguous parts within the same family group of procedures, the first procedure is paid in full and all other procedures within the same family are reimbursed at 75% of the MAP (25% reduction of total technical payment). The multiple procedure payment reduction applies only within a given family code group.

> **Example:** If an MRI is performed, in the same session, on the cervical spine and on the lumbar spine (both procedure codes are included in family 6) the procedure with the **highest relative** value is paid in full and the **technical** component for the secondary procedure would be paid at 75% of the MAP.

The following is an explanation key for the Diagnostic Imaging Family Indicator column on the Radiology fee schedule.

Diagnostic Imaging Family Indicator	Identifies the applicable diagnostic service family for those HCPCS codes affected by the multiple procedure rule (R 418.10504). The values on the Radiology fee schedule correspond to the following: 01=Ultrasound (Chest/Abdomen/Pelvis-Non-Obstetrical) 02=CT and CTA (Chest/Thorax/Abd/Pelvis) 03=CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) 04=MRI and MRA (Chest/Abd/Pelvis) 05=MRI and MRA (Head/Brain/Neck) 06=MRI and MRA (Spine) 07=CT (Spine) 08=MRI and MRA (Lower Extremities) 09=CT and CTA (Lower Extremities) 10=MR and MRI (Upper Extremities and Joints) 11=CT and CTA (Upper Extremities) 99=Family Concept Does Not Apply

A chart describing the radiologic families (with CPT® codes within each family) affected by the multiple payment reduction policy follows this key.

Family 1 Ultrasound (Chest/Abdomen/Pelvis/non OB)

76604	76775
76700	76831
76705	76856
76770	76857

Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis)

71250	72194
71260	74150
71270	74160
71275	74170
72191	74175
72192	75635
72193	0067T

Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck

70450	70487
70460	70488
70470	70490
70480	70491
70481	70492
70482	70496
70486	70498

Family 4 MRI and MRA (Chest/Abd/Pelvis)

71550	72197
71551	72198
71552	74181
71555	74182
72195	74183
72196	74185

Family 5 MRI and MRA (Head/Brain/Neck)

70540	70548
70542	70549
70543	70551
70544	70552
70545	70553
70546	70555
70547	

Family 6 MRI and MRA (Spine)

72141	72149
72142	72156
72146	72157
72147	72158
72148	

Family 7 CT (Spine)

72125	72130
72126	72131
72127	72132
72128	72133
72129	

Family 8 MRI and MRA (Lower Extremities)

73718	73722
73719	73723
73720	73725
73721	

Family 9 CT and CTA (Lower Extremities)

73700	73702
73701	73706

Family 10 MR and MRI (Upper extremities & Joints)

70554	73221
73218	73222
73219	73223
73220	

Family 11 CT and CTA (Upper Extremities)

73200	73202
73201	73206

Contrast Media

Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services, (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).

When a radiology CPT® procedure code includes the use of contrast materials in the description, no additional payment is made for the contrast materials as they are included in the procedure.

Low osmolar contrast material and paramagnetic contrast materials shall only be billed when instructions indicate supplies shall be listed separately. Contrast materials are reimbursed at wholesale price and a copy of the invoice documenting the wholesale price should be attached to the charges. These supplies are billed with HCPCS codes.

X-Ray Consultation (CPT® 76140)

CPT ® code 76140, x-ray consultation, will only be paid when there is a documented need for the service and when performed by a radiologist or physician certified to perform radiological services. When procedure code 76140 is billed, the written report must accompany the charges.

> **Note:** Billing code 76140 is not appropriate in the following circumstances because review of the x-rays is included in the E/M code:

- The physician, during the course of an office visit or consultation, reviews an x-ray that was were taken elsewhere.
- The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

Billing

Radiologists, billing only the professional component, are not required to enter a diagnosis code in Element 21 of the CMS-1500.

When a CPT® code descriptor indicates a minimum number of views, the number listed indicates the *minimum* number of views required for that service, not the maximum. No payment will be made for views in excess of the minimum number.

*Billing a **Total Procedure** (Professional and Technical Component)*

When a physician performs both the professional and technical components, bill the appropriate CPT® radiology code without a modifier.

*Billing the **Professional** Component (Modifier -26)*

To bill for the professional component of a procedure, such as the reading of a radiology service provided by a hospital or diagnostic center, use the appropriate CPT® code and the modifier -26.

Professional services will not be reimbursed when:

- The physician, during the course of an office visit or consultation, reviews an x-ray taken elsewhere.
- The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

> **Note:** Should the provider fail to add modifier -26 to a radiology procedure provided in a hospital or other facility, payment will only be made for the professional component.

*Billing the **Technical** Component (Modifier -TC)*

When the technical component is provided by a health care provider other than the physician providing the professional component, the health care provider bills for the technical component by adding modifier -TC to the applicable radiology code.

Billing for Radiological Supervision and Interpretation

When a radiologist and a clinician work together as a team (e.g., when the clinician injects contrast media and the radiologist supervises and interprets the procedure) each must bill separately for services rendered.

To bill for the service rendered by the clinician in this case, use the applicable surgical injection procedure code. Payment for the injection includes all the usual physician services for injections (e.g., pre-and post-injection services, local anesthesia, placement of needle or catheter, and the injection itself).

To bill for the **service rendered by the radiologist**, use the applicable radiology CPT® procedure code with a descriptor that specifies "supervision and interpretation only."

<u>Radiology Modifiers</u>

-26 **Professional Component:** Radiology procedures are a combination of a physician and technical component. When only the physician professional component is reported use the modifier (-26). A written report is required whenever modifier (-26) describes the radiology service.

-TC **Technical Component:** Radiology procedures are a combination of a physician and technical component. When billing for only the technical component of a procedure, use the modifier (-TC). A hospital is not required to place modifiers on the UB-04.

Chapter 10

Laboratory and Pathology

This section stipulates only those policies and procedures that are unique to pathology and laboratory services and are billed with CPT® codes 80048-89356. Additional policies and procedures applying to all providers can be found in Chapters 1-5 of this manual. Fees for laboratory procedures are set in accordance with R 418.101503. Fees for pathology services are based on RBRVS. Separate fee tables will be published for laboratory and pathology procedures. All other laboratory codes without fees or relative value units assigned are "by report" and are reimbursed at the provider's usual and customary charge or reasonable, whichever is less.

Procedure codes in the 8000 series of codes published by CPT® may be billed by a clinical laboratory, or in some instances, by a physician's office. Some laboratory and pathology services may require interpretation by a physician. In this case, there may be a separate bill for the technical and professional components of the procedure. The technical component represents use of the laboratory equipment and the technician's services. The professional component is the physician's interpretation and report of the test. When billing for the professional or the technical component, use the appropriate modifier. No modifier is required when billing for the total procedure.

Laboratory and pathology procedures may be billed by a hospital as either an inpatient or outpatient service. When billed by a hospital on the UB-04, the services are identified with the appropriate CPT® procedures and the hospital is reimbursed by the cost-to-charge ratio methodology.

Documentation for both laboratory and pathology procedures is not required for payment. Should the carrier request the records; the provider will be reimbursed in accordance with the copying charge rule (R 418.10118).

<u>Modifiers</u>

-26 **Professional Component:** Pathology and lab procedures are a combination of a physician and technical component. When only the physician is reported, use the modifier (-26).

-TC **Technical Component:** When billing for only the technical component of a procedure, use the modifier (-TC).

Chapter 11

Medicine

This section stipulates only those policies and procedures that are unique to the medical services covered in this section. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual. An evaluation and management service is referred to as an E/M service and is covered in Chapter 6 of this manual.

Manipulative Services

Chiropractic and osteopathic manipulative services, which are medicine services, will be discussed in Chapter 12 with the physical medicine services.

Audiological Function Tests

The audiometric tests (92551-92596) require the use of calibrated electronic equipment. Other hearing tests (e.g., whisper voice or tuning fork) are considered part of the general otorhinolaryngologic services and are not paid separately. All descriptors refer to testing of both ears.

Psychological Services

Payment for a psychiatric diagnostic interview includes history and mental status determination, development of a treatment plan, when necessary, and the preparation of a written report that must be submitted with the required billing form.

Psychotherapy (CPT® codes 90804-90857) must be billed under the CPT® code most closely approximating the length of the session. The codes for individual therapy services designate whether the service includes medical evaluation. Only a psychiatrist (M.D. or D.O.) may bill for those codes that include medical evaluation (procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, or 90829). **Psychiatrists are NOT required to use a modifier.**

A **service level adjustment factor (SLAF)** is used to determine payment for psychotherapy when a provider other than a fully licensed psychologist provides the service(s). In those instances, the procedure codes must be identified with the **appropriate modifier identifying the provider**. The MAP amount or the provider's usual and customary fee is then reduced by the percentage for that specialty as noted in the following table:

Provider	Modifier	SLAF
Licensed Psychologist	**-AH**	**100**
Limited License Psychologist	**-AL**	**0.85**
Certified Social Worker	**-AJ**	**0.85**

Provider	Modifier	SLAF
Licensed Professional Counselor	**-LC**	**0.85**
Licensed Marriage and Family Therapist	**-MF**	**0.85**
Limited Licensed Counselor	**-CS**	**0.64**
Limited Licensed Marriage & Family Therapist	**-ML**	**0.64**

Note: A licensed psychologist or any of the above providers may not bill psychiatrists' codes that include medical evaluation of the patient.

Examples:

- When a fully licensed psychologist bills procedure code 90806, modifier -AH is required and the carrier payment is 100% of the MAP amount.
- If a limited license psychologist bills procedure code 90806, modifier –AL must be added and the carrier pays 85% of the MAP amount.
- If a limited licensed marriage and family therapist bills procedure code 90806, modifier –ML must be added and the carrier pays 64% of the MAP amount.

Biofeedback

Biofeedback is billed with procedure codes 90901-90911. Providers include physicians, physical therapists, and psychologists.

Neurology and Neuromuscular Services

Neurology services are typically consultation services and any of the five levels of consultation may be appropriately billed in addition to the diagnostic studies.

Diagnostic studies (Nerve Conduction Tests, Electromyograms, Electroencephalograms, etc.) may be paid in addition to the office visit or consultative service. A diagnostic study includes both a technical component (equipment, technical personnel, supplies, etc.) and a professional component (interpreting test results, written report, etc). Billing without a modifier indicates that the complete service was provided.

Electromyography (EMG)

Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG performed on the same day. When an EMG is performed on the same day as a follow-up visit (established patient), payment may be made for the visit only when documentation supports the need for the medical service in addition to the EMG.

Nerve Conduction

A nerve conduction study is the assessment of the motor and sensory functions of a nerve in an extremity. **Nerve conduction studies may include comparison studies when documented as medically necessary.**

Physicians may be paid for both a new patient visit/consultation and nerve conduction study performed on the same visit. When a nerve conduction study is performed on the same day as a follow-up visit, payment for the visit may be made only when documentation of medical necessity substantiates the need for the visit in addition to the nerve conduction study.

Ophthalmologic Services

Only an ophthalmologist or a doctor of optometry may bill procedure codes 92002, 92004, 92012, and 92014. A doctor of optometry shall use procedure codes 92002-92287 to describe services.

A medical diagnostic eye evaluation is an integral part of the ophthalmology service. Intermediate and comprehensive ophthalmologic services include medical diagnostic eye evaluation and services such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, and determination of refractive state, tonometry or motor evaluation.

Injectable Pharmaceuticals

Payment for injection codes includes the supplies usually required to perform the procedure, but not the medication. Injections are classified as subcutaneous, intramuscular, or intravenous. Each of the procedure codes describing a therapeutic injection has an assigned RVU and MAP amount.

> **Note:** A therapeutic injection does not include the immunization procedure codes.

When a therapeutic injection is given during an E/M service, the relative value for providing the injection is in the payment for the E/M service and must not be billed or paid separately. The cost of the injectable pharmaceutical may be billed using procedure code 99070 from CPT® or the appropriate J-Code listed in Medicare's Level II HCPCS codes. The NDC code shall be listed on the bill and the drug is reimbursed at AWP as determined in the current edition of Red Book.

When the injection is provided without an E/M service, and only the injection will be billed for that date of service, the injection and the medication should be listed separately on the CMS-1500. Report the injection by entering the appropriate CPT® injection code and report the medication as described in the preceding paragraph. The

payment for the injection is the MAP amount listed in this schedule. Payment for the medication is AWP as determined by Red Book.

Anesthetic agents such as Xylocaine and Carbocaine used for local infiltration are included in the payment for the procedure and will not be paid separately.

Modifiers

The following modifiers are used in medical services. Consult the current CPT® manual for a complete listing of modifiers.

-GF	Advanced practice nurse with a nursing board specialty certification.
-GF	A certified physician's assistant.
-26	Professional component.
-TC	Technical component.
-AH	Licensed psychologist.
-AL	Limited license psychologist.
-CS	Limited licensed counselor.
-LC	Licensed professional counselor.
-MF	Licensed marriage and family therapist.
-ML	Limited licensed marriage and family therapist.

Chapter 12

Physical Medicine and Manipulation

This section stipulates only those policies and procedures that are unique to physical medicine and manipulative services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

Manipulative Services

The initial office visit to determine the need for manipulative services is billed with the appropriate E/M procedure code by both chiropractic and osteopathic physicians. Ongoing manipulative services include a pre-manipulative patient evaluation. An E/M service **with ongoing manipulation** is only payable when documentation supports a significant change in signs and symptoms, or a periodic re-evaluation is required, or for the evaluation of another work related problem. **The E/M service would be reported using modifier -25.** Rationale for significant other services must be documented in the record.

The following documentation must be submitted to the carrier:

- The initial evaluation including:
  - Evaluation of function in measurable terms.
  - A goal statement.
  - Treatment plan.
  - Physical and functional improvement in measurable terms and what improvement should be noted if therapy were to continue.
- A progress report each 30 days of treatment.
- A discharge evaluation.

Chiropractic Manipulative Treatment (CMT) is billed with procedure codes 98940-98942. Procedure code 98943, which is not in the scope of practice for Michigan-based chiropractic physicians, is not payable to Michigan providers.

Osteopathic Manipulative Treatment (OMT) is billed with procedure codes 98925-98929.

Physical Medicine Services

Licensed chiropractors, physicians (M.D.'s and D.O.'s) physical and occupational therapists, dentists, and podiatrists may bill and be paid for physical medicine services in the 97000 CPT® series of codes. Physical medicine services will be paid when the therapy provided is likely to restore function and is specific to the improvement in the patient's condition.

Physical therapy is when physical medicine services 97001-97799 are provided by a licensed physical therapist and occupational therapy is when procedure codes 97001-97799 are provided by a registered occupational therapist. Physical and occupational therapists will use evaluation procedure codes within the physical medicine section (not the E/M codes) to describe the initial evaluation. Physicians and other providers would use the E/M service to describe the evaluation performed prior to beginning physical medicine services. When the services are billed, the initial evaluation is required as well as an update progress report every 30 days. Requests for additional notes may be charged for in accord with rule R 418.10118

Procedure 97010 is a bundled procedure code and shall not be reimbursed separately (e.g. hot packs, cold packs etc).

When the treating provider (M.D., D.O., chiropractor, dentist, or podiatrist) provides physical medicine services in the office, an office visit shall not be paid when the sole purpose of the visit is to evaluate the patient's progress in physical treatment. Evaluation and Management (E/M) services may be billed for the purpose of a re-evaluation when the documentation supports a change in signs and symptoms.

- Evaluation of on-going Chiropractic services is included with the CMT series of codes (98940-98942).
- Evaluation of on-going Osteopathic manipulation services is included with the OMT series of codes (98925-98929).

Periodic re-evaluations are appropriately billed to determine the need for additional services or discontinuation of services. Additionally, if there is a documented change in signs and symptoms, the E/M service is reimbursable as a separately identifiable other service and modifier –25 is appended to the CPT® code.

Note: Chapter 6 discusses appropriate office visits with on-going physical treatment.

Physical treatment services are payable on the same day as the evaluation. If **therapeutic procedures are performed on the same day as the evaluation**, appropriate modalities may also be billed.

Supervised modalities, those not requiring one-on-one contact by the provider, **will not be paid unless accompanied by therapeutic procedures**. (Manipulation services, procedure codes 98925-98942 are considered therapeutic procedures in addition to 97110-97546).

Constant attendance modalities, those services requiring one-on-one contact with the provider, may be billed and paid without being accompanied by the therapeutic procedures. **Phonophoresis** is billed with procedure 97035-22 and is reimbursed the same as 97035 plus $2.00 for the active ingredient. **Fluidotherapy,** a dry whirlpool treatment, shall be reported using code 97022.

Documentation and Policies

The following documentation must be submitted:

- The **initial evaluation** including:
  - **A treatment plan** with measurable goals.
  - Description of **objective findings.**
  - Documentation of **limitations.**
- Progress report every 30 days documenting progress towards measurable goals.
- Discharge summary.

Note: When no progress is documented towards the goals, a re-evaluation may be done to change the treatment plan or to discontinue treatment. Ongoing therapy should not be reimbursed unless a treatment plan with measurable goals has been submitted to the carrier.

Functional (Work) Capacity Assessment (FCA)

Procedure **code 97750** is used to report the functional capacity testing. Total payment for the initial **testing shall not exceed 24 units or 6 hours**. A copy of the report and notes must be submitted with the bill. No more than 4 additional units shall be paid for a re-evaluation if performed within 2 months of the initial FCA.

Work Hardening and Work Conditioning

Work hardening and work conditioning are **goal-oriented therapies** designed to prepare injured workers **for their return to work**. Use procedure codes 97545 and 97546 to report these services. Work hardening procedures are considered by report as no RVU is available and the carrier will reimburse at usual and customary or reasonable, whichever is less, unless a pre-determined contractual agreement is made.

Job Site Evaluation

A carrier may request a physician, a registered occupational therapist or a licensed physical therapist to complete a job site evaluation. Reimbursement for the job site evaluation is not based upon relative values, but is determined on a contractual basis between the carrier and the provider. A copy of the report must be included when submitting the bill to the carrier. The codes to bill for the job site evaluation are as follows:

Code	Work Comp Code	MAP
WC500	Job site evaluation: patient specific, initial 60 minutes.	BR
WC505	Each additional 30 minutes.	BR

Code	Work Comp Code	MAP
WC550	Job site treatment; patient specific, initial 60 minutes.	BR
WC555	Each additional 30 minutes.	BR
WC600	Mileage for job site evaluation or job site treatment per mile.	State rate

The mileage is reimbursed based upon the state approved rate that is in effect for the date of service. The state approved rate is based on the Federal Standard Mileage Rate (IRS determined rate). Travel reimbursement, for current as well as past years, is listed on the workers' compensation agency's home page www.michigan.gov/wca.

Extremity Splints

Extremity splints may be prefabricated, off-the-shelf, custom-made, or custom-fit. Prefabricated splints are billed using the appropriate HCPCS code or 99070. If there is no MAP listed for the procedure and if the charge exceeds $35.00 than an invoice shall be included with the bill. The service is reimbursed by the fee schedule or at a mark-up above invoice cost as outlined in R 418.101003b.

- Invoice cost of $ 35.01 to $100.00 shall receive cost plus 50%.
- Invoice cost of $100.01 to $250.00 shall receive cost plus 30%.
- Invoice cost of $250.01 to $700.00 shall receive cost plus 25%.
- Invoice cost of $700.01 or higher shall receive cost plus 20%.

If the charge is $35.00 or less then the carrier shall reimburse the providers charge. If the carrier disputes the charge as unreasonable the carrier must have documentation on file to substantiate the dispute.

When a therapist constructs a splint the service is described with procedure L3999. A report must be submitted with the bill to document the description of the splint, the time taken to construct the splint, and the charge for additional materials. When a therapist modifies a prefabricated splint, a report shall be included indicating the time taken to modify the splint and any additional material used.

Licensed physical and registered occupational therapists may bill orthosis 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.

If a registered 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.

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

L-codes are now separate from these rules. If an L-code procedure does not have an assigned maximum allowable payment, then the procedure shall be by report, "BR."

Supplies

All of the supplies (e.g., electrodes and solutions) necessary to perform any of the physical medicine services are included in the MAP amount for the procedure.

If a provider dispenses a supply (e.g., lumbar roll, support, or cervical pillow) it shall be billed with the appropriate HCPCS procedure or 99070. Reimbursement is made according to R 418.101003b as described above.

Medical supplies are not routinely used in the course of physical and occupational therapy. Dressings that must be removed before treatment and replaced after treatment may be billed and paid. The supplies should be billed with the appropriate code from Medicare's Level II HCPCS codes.

Billing Guidelines

When billing physical therapy or occupational therapy, **a physician's prescription** should be attached to the charges.

CPT® codes 97010-97028 are **supervised modalities** for the application of a modality to one or more areas and **are not billed according to units or minutes of service**. Procedure 97010 is a bundled procedure code and shall not be reimbursed separately. CPT® codes 97032-97039 are for the application of a modality to one or more areas, requiring one-on-one patient contact by the provider, and are billed in 15-minute increments. CPT® codes 97110-97762 require one-on-one patient contact by the provider and are billed in 15-minute increments.

The procedures 97**760** and 97**761** shall only be reimbursed when billed by **a registered** occupational or **licensed** physical therapist

Procedure code **97750** is used for reporting Functional Capacity Assessment (**FCA**) testing and testing by means of a mechanical machine. Use of a back machine (mechanical or computerized) is also reported using 97750**.**

Chapter 13

Special Reports and Services

This section lists only those policies and procedures, which are unique to special reports and services. Providers may bill these codes as they apply.

Nurse Case Manager

If a carrier assigns a nurse case manager or rehabilitation nurse to a workers' compensation case and the nurse accompanies the worker to the physician office visit, the provider may bill the carrier for the additional time and work involved secondary to the nurse case manager accompanying the worker.

A nurse case manager visit may be billed in conjunction with an office visit. The provider would bill the appropriate E/M procedure code and RN001. Both codes are reimbursed at 100%.

Additionally, if the case manager accompanies the worker to a routine follow-up visit during the global surgery period, the nurse case manager visit is billed with RN001. When the visit is for *routine, uncomplicated* care during the global surgery period, the E/M service is identified with 99024 and is not reimbursed separately as the visit is included in the global surgery package.

The carrier shall reimburse RN001 at $25.00.

Carrier or Employer Requested Visits for the Purpose of Job Restrictions or Revisions

When a carrier requests that a worker be seen during the global surgery period for the purpose of reviewing a worker's job tasks, job restrictions, or to make revisions or adjustments to the worker's job, then the carrier will reimburse the provider for the visit even though the visit occurs within the global follow-up period for the surgery.

The carrier is required to prior authorize the visit and must not deny the visit. The provider will bill the visit with procedure code 99455 using modifier -32 for carrier mandated service. The carrier shall reimburse 99455-32 at $70.00.

Carrier Requested Reports

If a carrier requests the provider to generate a report that is over and above the reports contained within the medical record, then the carrier must reimburse the provider for that report. The provider will bill the report with procedure code 99199 using modifier -32 for carrier requested service.

The carrier will reimburse the provider at $25.00 per page if the report is 3 pages or less. If the report is more extensive, reimbursement shall be considered "by report." Because the rules do not prohibit the carrier and provider from entering into a contractual agreement this report could also be reimbursed contractually.

Copies of Reports and Records

Providers are required to include certain copies of the medical record (refer to R 418.10113, R 418.10212, and R 418.10901(3)) when submitting claims. The provider may not charge the carrier for those required reports unless they are duplicates. When the carrier (or the carrier's agent) requests additional medical records pertaining to a **specific date of injury** or duplicate copies of the medical record, the provider may bill for those records. The carrier will reimburse the provider for the additional records or duplicate copies as follows:

- 45 cents per page, plus
- The actual cost of mailing the records, plus
- A handling fee of $2.50 for each 15-minute increment.

Medical records pertaining to a compensable specific date of injury may be requested by:

- A carrier or their agent (attorney or review company).
- An injured worker or their agent (attorney).

Note: The provider may bill their usual and customary charge for records, other than the case record, that do not pertain to a specific date of injury.

Chapter 14

Ancillary Services

The services cited in this chapter are considered ancillary services. Refer to Medicare's National Level II HCPCS codes for a complete listing of all ancillary procedures including descriptors.

Expendable Medical and Surgical Supplies (A4000-A8999).
Durable Medical Equipment (E0100-E9999).

Effective with the 2006 HCS rule update, a fee schedule has been established for the payment of durable medical equipment (DME) and expendable medical supplies. The fee schedule provides that these services shall be reimbursed at Medicare plus 5%. The fee including the 5% mark-up shall be listed in this manual.

Initial claims for rental or purchased DME shall be filed with a prescription for medical necessity including the expected time span the equipment will be required. If the item is dispensed out of a practitioner's office, the office notes, documenting medical necessity for the item, will replace the prescription. Modifier -RR shall identify rented DME on the provider's bill and modifier -NU shall identify the item as purchased, new.

When possible the carrier and the provider should agree, prior to dispensing, whether the item would be purchased or rented. If rented, DME shall be considered purchased once the monthly rental allowance exceeds the purchase price or when 12 consecutive months of rental has been reimbursed. If the worker's medical condition changes or does not improve as expected, then the rental may be discontinued in favor of purchase. If death occurs, rental fees for the equipment will terminate at the end of the month.

The exception to the above is oxygen equipment. Oxygen equipment shall be considered a rental as long as the equipment is medically necessary. The equipment rental allowance includes reimbursement for the oxygen contents.

> **Note:** The return of rented equipment is a dual responsibility between the worker and the DME supplier. The carrier is not responsible and shall not be required to reimburse for additional rental periods due to a delay in the return of rental equipment.

When Medicare does not list a fee, the supply or DME is considered by report. When the charge is $35.00 or less, the carrier shall reimburse the provider's charge or a reasonable amount. When the charge exceeds $35.00 an invoice must be included with the bill. Reimbursement for items billed with an invoice shall be as follows:

- Invoice cost of $ 35.01 to $100 shall receive cost plus 50%.
- Invoice cost of $100.01 to $250.00 shall receive cost plus 30%.

- Invoice cost of $250.01 to $700.00 shall receive cost plus 25%.
- Invoice cost of $700.01 or higher shall receive cost plus 20%.

Orthotic and Prosthetic Procedures (L0000-L9999).

Orthotic and Prosthetic Procedures L0000-L9999 shall be reimbursed by the carrier at Medicare plus 5%. The health care services division shall publish maximum allowable payments for L-code procedures in this manual separate from health care services rules. L-Code procedures not listed are "by report." The treating practitioner prescribes orthotic or prosthetic services. When these services are billed, a copy of the prescription is included with the charges. The by report procedures 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(s) provided.
- The time involved.
- The charge for materials/components.

Orthotic equipment or orthosis means an orthopedic apparatus or device that is designed to support, align, prevent, or correct deformities of, or improve the function of, a moveable body part. An orthotist is a practitioner skilled in the design, fabrication, and fitting of an orthosis or orthotic equipment. Orthotic equipment may be any of the following:

- Custom-fit which means the device is fitted to a specific patient.
- Custom-fabricated which mean the device is made for a specific patient from individualized measurements, pattern, or both.
- Non-custom supply means that the device is prefabricated, off-the-shelf, requires little or no fitting, and minimal instruction. A non-custom supply is intended for short-term use and does not include prosthetic procedures.

Prosthesis means an artificial limb or substitute for a missing body part. A prosthesis is constructed by a prosthetist, a practitioner who is skilled in the design, fabrication, and fitting of artificial limbs or prosthesis.

Other Ancillary Services

The following ancillary services are by report (BR) and are reimbursed at either the practitioner's usual and customary charge or reasonable as defined by the health care services rules. A complete listing of all of the procedure codes and their descriptors may be found in Medicare's National Level II HCPCS:

- **Ambulance Services** (Codes A0021-A0999).
- **Dental Procedures** (D0120-D9999).

- **Vision Services** (V0000-V2999).
- **Hearing Services** (V5000-V5999).
- **Home Health Services** (Primarily found in the S Section of HCPCS).

With the exception of dental and home health services, ancillary services are billed on the CMS-1500 claim form. These services are reimbursed at either the practitioner's usual and customary charge or reasonable, whichever is less as defined by the health care services rules in R 418.10109.

> **"Reasonable amount"** is defined as a payment based upon the amount generally paid in the state for a particular procedure code. Data from all other payers across the board may be considered when determining reasonable payment.
>
> **"Usual and Customary charge"** means a particular provider's average charge for a procedure to all payment sources, calculated based on data beginning January 1, 2000.

Dental services are billed on the standard American Dental claim form.

Home health services are billed on the UB-04 and each listed code is by report. If supplies are dispensed through the home health provider they will be reimbursed according to R 418.101003b as described earlier in this section. Progress notes will be submitted with the charges to document the services and supplies on the bill. If a home health agency bills for therapy services by an occupational therapist, a physical therapist, or a speech and language pathologist, the agency will use the appropriate HCPCS code(s) to describe the therapy services. Therapy services may be reimbursed at a per diem rate when the code is described as a per-diem service or by the total time of the service if the procedure billed indicates it is time-based. Per-diem would be a daily rate or visit.

Chapter 15

Facility Services

This section stipulates policies and procedures that are unique to hospitals and other facilities. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

General Information and Overview

Facilities that are licensed by the state of Michigan will be paid in accord with the Health Care Services Rules for services provided to injured workers. A carrier is not required to pay for facility services when a facility is not licensed. A facility may not balance-bill an injured worker for compensable services rendered to treat a work related illness or injury.

When a hospital located outside the state of Michigan bills a carrier for services rendered to a Michigan injured worker, the carrier may use the out-of-state ratio to process the charges. If the out-of-state hospital does not accept the Michigan fee schedule, the carrier must resolve the issue with the provider to prevent the Michigan injured worker from being balance-billed.

The rules base practitioner reimbursement on the site of service and will publish Maximum Allowable (MAP) payments for facility and non-facility. All hospital services are reimbursed by the cost-to-charge ratio methodology.

Licensed Facility Services (including hospitals)

A facility, as defined by the Health Care Services Rules, shall submit facility charges on a UB-04 claim form to the carrier. The exception to this is the freestanding surgical outpatient facilities (FSOF) that will bill workers' compensation services, the same as they do Medicare services, on the CMS-1500 claim form. The "Official UB-04 Data Specifications Manual" contains instructions for facility billing and can be ordered from the American Hospital Association, National Uniform Billing Committee – UB-04, P.O. Box 92247, Chicago, IL 60675-2247, 1-312-422-3390.

A hospital or a facility shall include the following information on the UB-04 claim form:

- Revenue codes.
- ICD.9.CM code.
- CPT® / HCPCS codes for identifying the surgical, radiological, medicine, laboratory, E/M and ancillary services.

A hospital billing for outpatient laboratory or physical medicine services (e.g., physical, occupational, hearing and speech therapy) will identify the services performed with

revenue codes as the services are reimbursed by the cost to charge methodology. CPT® procedural coding is also added to identify what physical medicine procedures are being billed on the UB. Refer to Part 9, Section B, of the Health Care Rules for facility billing. Reimbursement for facility services is found in Part 10, Section B, of the Workers' Compensation Health Care Services Rules.

A facility billing for a practitioner service shall submit the charges on the CMS-1500 claim form.

Examples of Facility Billing for Practitioner Services:

- A hospital billing for a CRNA or anesthesiologist, or both.
- A hospital billing for a radiologist.
- Professional component of a laboratory or medicine service.
- A hospital or hospital system-owned occupational or industrial clinic.
- A hospital or hospital system-owned office practice.

Free Standing Surgical Outpatient Facilities (FSOF)

The freestanding surgical outpatient facilities shall bill the facility service on the CMS-1500 claim form using modifier -SG and place-of-service 24 designating the service as performed in a freestanding surgical outpatient facility. FSOFs shall be licensed by the state under part 208 of the public health code. The owner or operator of the facility makes the facility available to other physicians, dentists, podiatrists or providers comprising the professional staff.

> **Note:** Hospital owned freestanding surgical outpatient facilities billing with the hospital's Tax ID number will continue to bill on the UB-04 and shall be reimbursed by the hospital's ratio methodology.

The facility payment for the surgical procedure is global and includes the supplies for the procedure. The freestanding surgical outpatient facility shall only perform and bill for procedures, which in the opinion of the attending physician, can be safely performed without requiring overnight inpatient care and exclusive of such surgical and related care as licensed physicians, ordinarily, elect to perform in their private office.

The methodology for paying the freestanding surgical outpatient facilities is based upon the Medicare payment methodology for ambulatory surgery centers (ASC) assigning the surgical procedures to groupers. Medicare assigns an allowable rate to each of the groupers and publishes the rates in the Federal register.

Michigan workers' compensation has elected to use one wage index of 1.0678 representing urban southeast Michigan. Workers' compensation reimbursement for the FSOF procedures shall be 80% above the Medicare reimbursement. The following

formula shall be used to determine the payment for the surgical procedure billed by the FSOF:

[Medicare payment for the grouper] X [wage index of 1.0678] X [1.8]

The maximum allowable payments for the procedures performed in a freestanding surgical outpatient facility are listed with the surgery maximum allowable payments (MAP) in the column with FSOF MAP for the heading.

The following billing and payment rules shall apply:

- FSOF charges shall be billed on the CMS-1500 claim form with site of service 24 and modifier -SG shall indicate the service is performed in an FSOF. Supplies are included in the surgical procedure. The carrier shall pay the maximum allowable payment or the provider's charge, whichever is less, as determined by the rules and published in this manual.
- Surgical procedures are paid using the multiple-surgery rule. The first procedure is paid at 100% of the maximum allowable or the billed charge, whichever is less and the remaining procedure(s) are paid at 50% of the maximum allowable or the billed charge, whichever is less.
- Surgical procedures shall not be unbundled.
- Bilateral procedures shall be placed on 2 lines of the claim form and modifier -LT shall designate left and modifier -RT shall designate right. Modifier -50 is not valid for the FSOF claim. The multiple surgery payment rule applies.
- Appropriate laboratory procedures may be billed and will be reimbursed at the maximum allowable payment or the provider's charge, whichever is less, as determined in R 418.101503.
- Durable medical equipment may be billed as necessary and will be paid in accord with R 418.101003b.
- If an x-ray is performed during the surgical procedure, only the technical component shall be billed and paid. The professional part is included as part of the surgical procedure. Pre-operative and post-operative radiology services may be globally billed and paid as reasonable and necessary.
- Items implanted into the body that remain in the body at discharge from the facility may be billed separate from the surgical procedure. The facility shall bill implant items with the unlisted CPT® drug and supply code, 99070. A report listing a description of the implant and a copy of the facility’s cost invoice shall be included with the bill. Some examples of implants are metal plates, pins, screws and mesh. The implants shall be reimbursed as follows:
  - Cost of implant: $1.00-$500.00 shall receive cost plus 50%.
  - Cost of implant: $500.01-$1,000.00 shall receive cost plus 30%.
  - Cost of implant $1,000.01 or higher shall receive cost plus 25%.
- Practitioner services shall not be included on the facility bill.

FSOF Grouper Payments:

The maximum payments listed in the table below have already had the wage index and 80% mark-up applied and **do not** require further calculation.

Grouper	MAP - FSOF 2008	Grouper	MAP - FSOF 2008	Grouper	MAP - FSOF 2008
1	$640.04	20	$205.20	39	$580.53
2	$857.23	21	$244.41	40	$599.81
3	$980.24	22	$244.87	41	$600.64
4	$1,210.89	23	$252.75	42	$621.36
5	$1,378.10	24	$253.44	43	$644.67
6	$1,587.61	25	$267.16	44	$664.70
7	$1,912.43	26	$278.66	45	$676.40
8	$1,870.14	27	$289.69	46	$716.81
9	$2,573.61	28	$316.02	47	$751.42
10	$72.10	29	$342.22	48	$760.69
11	$90.95	30	$353.33	49	$767.36
12	$128.62	31	$402.63	50	$786.75
13	$128.99	32	$428.19	51	$804.35
14	$139.31	33	$454.41	52	$813.22
15	$166.05	34	$461.29	53	$892.11
16	$170.02	35	$464.69	54	$1,908.49
17	$175.37	36	$472.67	55	$2,413.24
18	$191.88	37	$483.43	56	$2,394.57
19	$199.16	38	$575.15		

Other Facilities

A licensed facility, excepting a free standing surgical outpatient facility, shall use the UB-04 claim form to submit charges and must follow the billing procedures outlined in the Official UB-04 Data Specifications manual. The following licensed facilities shall be reimbursed by its usual and customary charge or reasonable amount whichever is less:

- Nursing Home.
- County Medical Care Facility.
- Hospice.
- Hospital Long-Term Care Unit.
- Intermediate or Skilled Care Nursing Facility.

When a licensed facility other than a hospital bills radiology or laboratory services, only the technical services shall be billed on the UB-04 claim form. Any professional charges, including anesthesiology services, shall be billed on the CMS-1500 claim form.

Note: To verify facility licensure, the carrier may contact the Bureau of Health Systems at (517) 241-2626. A booklet listing all of the licensed facilities and the addresses can be purchased from the Bureau of Health Systems, PO Box 30664, Lansing MI, 48909.

Reimbursement for Hospital Facility Services

A hospital shall bill facility services to the carrier in accordance with R 418.10922. The hospital is required to provide **only** the following records for a properly submitted bill:

- Emergency Room record.
- Anesthesia report (when billing anesthesiologists or CRNA services).
- Physical Medicine services (PT, OT, Speech and Hearing evaluations and subsequent reports every 30 days).

The carrier may request any other records necessary for utilization review and pay for those records in accordance with R 418.10118. Once compensability has been determined, withholding payment for copies of related lab and x-ray reports is **not** appropriate.

The carrier shall not ***routinely*** require the hospital to submit invoice documentation of implants or other charges on the in-patient/out-patient bill.

Hospital Payments by Ratio Methodology

The carrier will use the following formulas to calculate hospital reimbursement for ratio methodology payments:

- **Paying a properly submitted bill within 30 days**:
  (Appropriate charges x hospital ratio for the date of service x 107%)

- **Paying a properly submitted bill after 30 days**:
  (Appropriate charges x hospital ratio for the date of service x 110%)

Chapter 16

Agency and Miscellaneous Information

This section contains contact information and examples of the forms used in workers' compensation. Also included in this chapter are samples of the provider claim forms.

Agency Contact Numbers

Providers may obtain ***current*** carrier information from the website as listed below and going to the quick link "Insurance coverage look-up" on the right side of the page and entering the employer name. The link will not ensure correct carrier information for previous dates. A provider may call (517) 322-1885 or (888) 396-5041(prompt #2) to obtain **carrier information**. When calling, be sure to have the following information:

- The employer's name and address.
- The date of injury.

Questions from an **injured worker** may be directed to (517) 322-1980 or (888) 396-5041 (prompt #1 from the first menu if they have a touch tone phone then prompt #1 from the 2nd menu).

Fee schedule and billing questions may be directed to (517) 322-5896, (517) 322-5430, (517) 322-5433 or (888) 396-5041 (prompt #6).

The Health Care Services Rules and Fee Schedule may be downloaded, at no charge, from the Workers' Compensation Agency website: **http://www.michigan.gov/wca**. For assistance in accessing the **Health Care Services Rules or Fee Schedule on line** call **(517) 322-5433 or (888) 396-5041 (prompt #6).**

Providers with questions about **completing the 104B form** may call (517) 322-5430 or (888) 396-5041 (prompt #6). Other questions may be directed to (517) 322-5991 or (888) 396-5041 (prompt #8).

> **Note:** Hearings are generally scheduled within 6-8 weeks. Allow for this processing time to elapse before contacting the Workers' Compensation Agency.

Carriers may direct questions regarding the completion of the forms, "Annual Medical Payment Report" (WCA-406) or "Certification of the Carriers' Professional Review Program" (WCA-590) to (517) 322-5430 or (888) 396-5041 (prompt #6).

Workers' compensation forms and information may be obtained by calling (888) 396-5041 (prompt #3). Requests for forms and other information can either be e-mailed to wcinfo@michigan.gov or faxed to (517) 322-1808. All requests should include a contact name, phone number, company, street address, city, state, zip code, the requested form name and/or number, and quantity. In addition, you may print **selected** forms directly from our website: www.michigan.gov/wca

Forms

- **Sample Reconsideration:** This is not a required form and is optional for provider usage.

- **Provider's Report of Claim (117H):** This is not a required form. Provider use of the form is optional when an employer does not report the claim. Do not send this form to the Workers' Compensation Agency.

- **Application for Mediation (WC-104B):** This form is submitted on behalf of Health Care Providers, Insurance Companies or Self-Insured Employers to resolve disputes involving medical services. Compliance with the Health Care Services rules is **mandatory** before requesting a mediation hearing (Parts 9, 10 and 13 of the HCS rules). This form is available, at no charge, from the Agency. If you choose to duplicate this form or download it from the Agency website, it **must** be identical to the agency form or it will be returned. The most current version of the form must be submitted to the agency and a copy must go to the carrier. Refer to the contact information given above to verify the current version date and to order this form.

- **Carriers Explanation of Benefits (WC-739 Rev. 4-07).**

- **Annual Medical Payment Report (WC-406).**

- **A Hospital's Request for Adjustment to their Maximum Payment Ratio (WC-581).**

- **Application for Certification of a Carrier's Professional Health Care Review Program (WC-590).**

- **Notice of Certification of a Carrier's Professional Health Care Review Program (WC-591).**

Claim Forms

- The standard practitioner claim form is the most recent CMS-1500 form (08/05). To obtain this form, contact the AMA at (800) 621-8335 or at www.ama-assn.org
- The standard facility claim form is the most recent UB-04 form (CMS-1450). To obtain this form, contact the American Hospital Association - National Uniform Billing Committee at (312) 422-3390 or at www.nubc.org
- The standard ADA claim form (dental claim form). To obtain this form, contact the ADA at (800) 947-4746 or go online at www.adacatalog.org
- The universal pharmacy claim form.

Source Documents

The following source documents adopted by reference in the Health Care Services Rules, R 418.10107, and were used in preparing this manual. You may order these documents from the publisher:

- Physicians Current Procedural Terminology (CPT®).
- Medicare's National Level II Codes, (HCPCS).
- RBRVS, Fee Schedule: The Physicians' Guide.
- International Classification of Diseases.
- Red Book.
- Official UB-04 Data Specifications Manual.

Sample Reconsideration

WORKERS' COMPENSATION HEALTH CARE SERVICES PROVIDER'S REQUEST FOR RECONSIDERATION

COPY 1 CARRIER COPY 2 PROVIDER	REQUEST DATE

PROVIDER NAME			EMPLOYEE NAME		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
SOCIAL SECURITY/FEIN NUMBER*			SOCIAL SECURITY NUMBER*		
PATIENT ACCOUNT NUMBER			DATE OF BILL	DATE OF INJURY	

CARRIER NAME				TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE	CLAIM NUMBER
EMPLOYER NAME				

DATE(S) OF SERVICE

CHARGE $	PAYMENT $	REQUESTED AMOUNT	$

REASONS FOR RECONSIDERATION (Detailed Statement)

DOCUMENTS ATTACHED:		BWC-739		REQUESTED REPORT
		OFFICE NOTES		BILL

CONTACT PERSON AND TELEPHONE NUMBER

_____

*PROTECTED INFORMATION TO BE USED FOR IDENTIFICATION PURPOSES

APPLICATION FOR CERTIFICATION OF A CARRIER'S PROFESSIONAL HEALTH CARE REVIEW PROGRAM

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Date of Application	**Initial** ☐	**Renewal** ☐
Note: A new application must be submitted whenever there is a change in carrier, service company, or review company.		

This form is required in accordance with Part 12, R 418.101206 of the Workers' Compensation Health Care Services Rules to receive certification of a carrier's professional review program.

I. CARRIER

Carrier	**Service Company**	**Review Company**
NAIC No., Self-Insured No., or FEIN	Agency Assigned Number	Employer Identification
Name	Name	Name
Address (Street)	Address (Street)	Address (Street)
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Telephone No. (Include area code)	Telephone No. (Include area code)	Telephone No. (Include area code)
Contact Person	Contact Person	Contact Person

II. METHODOLOGY/REVIEW STAFF AND CREDENTIALS

Attach methodology; according to the workers' comp agency procedure, used to perform a carrier's professional review.

R 418.101204(5)(a)-(c) requires that medical appropriateness of services shall be determined through one of the following approaches:

1) Review by licensed, registered, or certified health care professionals.
2) The application by others of criteria developed by licensed, registered, or certified health care professionals.
3) A combination of (1) and (2) according to the type of covered injury or illness.

The methodology should include a list of all licensed, registered, or certified health care professionals reviewing case records and medical bills for the above carrier. Provide current licensure information (license #, state of issue, date of expiration and restrictions) and qualifications for medical bill review. In addition, include a list of all peer reviewers with current license information and specialty.

*When a service company submits applications for numerous self-insured employers, and the methodology is identical, it is not necessary to submit the professional review methodology more than once. The workers' compensation agency will maintain on file, the review methodology for each service company.

**Methodology for professional certification must be submitted once every three years or whenever changes occur.

III. AUTHORIZED SIGNATURE

By signing this form, I certify that the information included on this form is correct and complete to the best of my knowledge and that the professional review methodology is attached or has already been submitted by the service company and/or their designated agent. I understand that submitting false information is cause for denial of the application or will subject me to penalties as provided by law.

Authorized Signature (In Ink)	**Authorized Name (Typed)**	**Date**

WC-590 (REV 1-04)

ANNUAL MEDICAL PAYMENT REPORT
Michigan Department of Energy, Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
P.O. Box 30016, Lansing, MI 48909

ANNUAL REPORTING PERIOD: 1/01/___ to 12/31/___
(Due by February 28th the Year Following the Reporting Period)

I. CARRIER INFORMATION

Carrier Name (Insurance Co., Self-Insured, or Fund)	NAIC or Self-Insured No.
Address (number & street)	Telephone No. (include area code)
City, State, Zip Code	Carrier Contact Person
Service Co. Submitting Information for Self-Insured/Self-Administered	Service Co. Contact Person & Telephone No. (include area code)

II. ANNUAL MEDICAL PAYMENT REPORT

Include data for payment of all medical expenditures. **Please see note at bottom of page.**

Do not include payments for the following:

a. Indemnity payments
b. Mileage reimbursement
c. Vocational rehabilitation or medical case management expenses
d. Independent medical examinations or legal expenses

CASE TYPE	NUMBER OF CASES	TOTAL DOLLARS SPENT FOR MEDICAL CARE
Medical Only		$
Wage Loss		$

By signing this form, I certify that the information included in this annual medical payment report and accompanying attachments, if any, is true, correct and complete to the best of my knowledge.

Authorized Signature	Authorized Name (typed or printed)	Date

The Department of Energy, Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.	Authority: Workers' Compensation Health Care Services Rules, part 14, R418.101401 Completion: Mandatory. Must be completed and submitted to the agency by 2/28 annually for the previous year. Penalty: Failure to provide data shall prevent certification of the Carrier's Professional Health Care Review Program pursuant to part 12, R418.101206

Note: A separate WC-406 form is required for <u>each</u> individual Carrier, Carrier Number/NAIC Number, Self-Insured Employer, and every entity within a Group Fund. A WC-406 with a compilation for all companies within a Carrier "Group" is not acceptable.

WC-406 (Rev. 4/09)

APPLICATION FOR ADJUSTMENT TO THE WORKERS' COMPENSATION MAXIMUM PAYMENT RATIO

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Application Date	
Fiscal Year	

This form is required in accordance with Part 11, R 418.101103 of the Workers' Compensation Health Care Services Rules for an adjustment to the workers' compensation maximum payment ratio. A Hospital should not submit the form unless the hospital is eligible to receive an increased adjustment in accord with R 418.101103.

I. Hospital

Name	**Employer Identification Number**
Address (Street)	**Telephone No. (Include area code)**
City, State, ZIP Code	**Contact Person**

II. Cost Information

This information is required pursuant to R 418.101102 for the calculation and revision of the maximum payment ratio. All information below should be for a hospital=s most recent completed fiscal year.

a. Enter total operating expenses for most recent year as reported on the Astatement of patient revenues and operating expenses, G2 worksheet.	**$**
b. Enter total patient revenues for most recent fiscal year as reported on the Astatement of patient revenues and operating expenses, G2 worksheet.	**$**
c. Total charges for all worker=s compensation cases.	**$**

By signing this form, I certify that the information included on this form and accompanying attachments, if any, is true, correct, and complete to the best of my knowledge. I understand that submitting false information is cause for denial of the underpayment adjustment or will subject me to penalties as provided by law.

Authorized Signature (In ink)	Authorized Name (Typed)	Telephone No. (Including Area Code)	Date

Copy 1 Health Care Services Division

Copy 2 Hospital

WC-581 (REV. 1-04)

Copy 1	Provider
Copy 2	Carrier
Copy 3	Employee

Carrier's Explanation of Benefits

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division

Date processed
Page

DIRECT ALL PAYMENT INQUIRIES AND REQUESTS FOR RECONSIDERATION TO THE CARRIER

Carrier Name	Service Company			NAICS/Self-Insured
Street Address	City	State	Zip Code	Telephone Number
Employer Name				Claim Number

Provider Name			Employee Name		
Street Address			Street Address		
City	State	Zip Code	City	State	Zip Code
National Provider Identification Number (NPI)/FEIN Number*			Social Security Number *		
Patient Account Number			Date of Injury	Date of the Provider Bill	Date bill received by Carrier

PROVIDER:
IF YOU INTEND TO SEEK RECONSIDERATION, PLEASE CONTACT THE CARRIER INDICATED ABOVE WITHIN 60 CALENDAR DAYS OF RECEIPT OF THIS NOTICE. IF ADDITIONAL INFORMATION IS REQUESTED, PLEASE FORWARD THE INFORMATION TO THE CARRIER.

EMPLOYEE:
FOR INFORMATION ONLY. THIS IS NOT A BILL. IF YOU ARE BILLED FOR ANY SERVICES RELATED TO THIS WORKERS' COMPENSATION CLAIM, DO NOT PAY. DO CALL THE CARRIER LISTED ABOVE.

Date of Service	Place of Service	Procedure Code and Modifier	Description--If Needed	Diagnosis Code	Days or Units	Charge	Payment	Note

Provider/Employee: R 418.10105 and R 418.101301(3) of the Worker's Compensation Health Care Services Rules require that the carrier 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 when that amount is disputed by the carrier pursuant to its utilization review program or when the amount exceeds the maximum allowable payment established by these rules. The carrier shall request the employee to notify the carrier if the provider bills the employee.	Total Charge	Payment

This form is required as set forth in Part 1, R 418.10117 (4), Part 10, R 418.101001 (4) and Part 13 R 418.101301 (1) of the Workers' Compensation Health Care Services Rules.

***PROTECTED INFORMATION TO BE USED FOR IDENTIFICATION PURPOSES**

WC-739 (Rev.4-07)

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination /Preauthorization
☐ EPSDT/Title XIX

2. Predetermination /Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan /Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan /Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient /Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness /injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured /subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Sample

ADA.

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

GENERAL INSTRUCTIONS

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.
B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.
C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.
D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.
E. All dates must include the four-digit year.
F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

NATIONAL PROVIDER IDENTIFIER (NPI)

49 and 54 NPI (National Provider Indentifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Internet Web Site: **www.ada.org/goto/npi**

ADDITIONAL PROVIDER IDENTIFIER

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

PROVIDER SPECIALTY CODES

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at:
www.ada.org/goto/dentalcode

Sample

Universal Pharmacy Claim Form

GROUP NO. ☐ _____ CARDHOLDER I.D. NO _____ OTHER THIRD PARTY COVERAGE ☐ YES ☐ NO

CARD-HOLDER NAME _____ LAST _____ FIRST _____ INITIAL

FOR OFFICE ONLY

PHARMACY INFORMATION

NAME

STREET NO.

CITY, ST ZIP

PHARM NO.

PHONE

PATIENT LAST NAME	FIRST & INITIAL	DATE OF BIRTH MO	DAY	YR	SEX M	F	RELATIONSHIP TO CARDHOLDER CARDHOLDER	SPOUSE	CHILD	OTHER

SEE SIGNATURE

DATES RX'S WRITTEN MO	DAY	YR

DATES RX'S FILLED MO	DAY	YR

AUTHORIZED PHARMACY REPRESENTATIVE

		INGR COST
		DISP FEE
		TAX
		TOTAL PRICE
		DED AMT
		BAL

RX NUMBER	NEW REFILL	METRIC QUANTITY	DAYS SUPPLY	NATIONAL DRUG CODE LABELER NO	PRODUCT NO	PKG	PRESCRIBER INDENT.	DAW
1								
2								

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1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.