

DEPARTMENT OF ENERGY, LABOR & ECONOMIC GROWTH

WORKERS' COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

Filed with the Secretary of State on June 30, 2009

These rules become effective 7 days after filing with the Secretary of State

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

R 418.10107, R 418.10109, R 418.10212, R 418.10214, R 418.10905, R 418.10117, R 418.101002a, R 418.101003, R 418.101006, R 418.101016, are amended, and R 418.10213 and R 418.101504 are rescinded in the Michigan Administrative Code.

R 418.10107 Source documents; adoption by reference.

Rule 107. The following documents are adopted by reference in these rules and are available for inspection at, or purchase from, the workers' compensation agency, health care services division, P.O. Box 30016, Lansing, Michigan 48909, at the cost listed or from the organizations listed:

(a) "Physicians' Current Procedural Terminology (CPT[®]) 2009," professional edition, copyright October 2008, published by the American Medical Association, PO Box 930884, Atlanta GA, 31193-0884, order # EP888809DJR, 1-800-621-8335. The publication may be purchased at a cost of \$102.95, plus shipping and handling as of the time of adoption of these rules. Permission to use this publication is on file in the workers' compensation agency.

(b) "Medicare's National Level II Codes, HCPCS, 2009," copyright December 2008, published by the American Medical Association, P.O. Box 930884 Atlanta GA 31193-0884, order # OP095109DJR, customer service 1-800-621-8335. The publication may be purchased at a cost of \$94.95, plus \$11.95 for shipping and handling as of the time of adoption of these rules.

(c) "Medicare RBRVS 2008: The Physicians' Guide," published by The American Medical Association, P.O. Box 930876, Atlanta GA 31193-0876, order #OP059608, 1-800-621-8335. The publication may be purchased at a cost of \$89.95, plus \$11.95 shipping and handling as of the time of adoption of these rules.

(d) "Medicare RBRVS 2009: The Physicians' Guide," published by The American Medical Association, P.O. Box 930884, Atlanta GA 31193-0884, order #OP059609DJR, 1-800-621-8335. The publication may be purchased at a cost of \$91.95, plus \$11.95 shipping and handling as of the time of adoption of these rules.

(e) "International Classification of Diseases, ICD-9-CM 2009 Volumes 1 & 2," copyright September 2009, American Medical Association, P.O. Box 930884, Atlanta GA 31193-0884, order #OP065109DJR, 1-800-621-8335. The publication may be purchased at a

cost of \$92.95, plus \$11.95 shipping and handling as of the time of adoption of these rules.

(f) "20079 Drug Topics Red Book," published by Thomson Healthcare DMS Inc, PO Box 2244, 82 Winter Sport Lane, Williston, VT 05495, 1-800-678-5689. The publication may be purchased at a cost of \$76.95, plus \$12.95 for shipping and handling as of the time of adoption of these rules.

(g) "Official UB-04 Data Specifications Manual 2009 (v. 3.00), July 1, 2008," developed in cooperation with the American Hospital Association's National Uniform Billing committee, published by American Hospital Association, National Uniform Billing Committee – UB-04, P.O. Box 92247, Chicago, IL 60675-2247, 1-312-422-3390. As of the time of adoption of these rules, the cost of the publication is \$150.00.

R 418.10109 Definitions; M to U.

Rule 109. As used in these rules:

- (a) "Maximum allowable payment" means the maximum fee for a procedure that is established by these rules, a reasonable amount for a "by report" procedure, or a provider's usual and customary charge, whichever is less.
- (b) "Medical only case" means a case that does not involve wage loss compensation.
- (c) "Medical rehabilitation" means, to the extent possible, the interruption, control, correction, or amelioration of a medical or a physical problem that causes incapacity through the use of appropriate treatment disciplines and modalities that are designed to achieve the highest possible level of post-injury function and a return to gainful employment.
- (d) "Medically accepted standards" means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services ensuring that the health care is suitable for a particular person, condition, occasion, or place.
- (e) "Morbidity" means the extent of illness, injury, or disability.
- (f) "Mortality" means the likelihood of death.
- (g) "New patient" means a patient who is new to the provider for a particular covered injury or illness and who needs to have medical and administrative records established.
- (h) "Nursing home" means a nursing care facility, including a county medical care facility, created pursuant to the provisions of 1885 PA 152, MCL 36.1.
- (i) "Orthotic equipment" means an orthopedic apparatus that is designed to support, align, prevent or correct deformities of, or improve the function of, a movable body part.
- (j) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.
- (k) "Practitioner" means an individual who is licensed, registered, or certified as used in the Michigan public health code, 1978 PA 368, MCL 333.1101.
- (l) "Primary procedure" means the therapeutic procedure that is most closely related to the principal diagnosis and has the highest assigned relative value unit (RVU).
- (m) "Properly submitted bill" means a request by a provider for payment of health care services which is submitted to a carrier on the appropriate completed claim form with attachments as required by these rules.

- (n) "Prosthesis" means an artificial substitute for a missing body part. A prosthesis is constructed by a "prosthetist", a person who is skilled in the construction and application of a prosthesis.
- (o) "Provider" means a facility, health care organization, or a practitioner.
- (p) "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from the provider, the carrier, or the workers' compensation agency, health care services division.
- (q) "Restorative" means that the patient's function will demonstrate measurable improvement in a reasonable and generally predictable period of time and includes appropriate periodic care to maintain the level of function.
- (r) "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.
- (s) "Specialist" means any of the following entities that are board-certified, board-eligible, or otherwise considered an expert in a particular field of health care by virtue of education, training, and experience generally accepted in that particular field:
- (i) A doctor of chiropractic.
 - (ii) A doctor of dental surgery.
 - (iii) A doctor of medicine.
 - (iv) A doctor of optometry.
 - (v) A doctor of osteopathic medicine and surgery.
 - (vi) A doctor of podiatric medicine and surgery.
- (t) "Subrogation" means substituting one creditor for another. An example of subrogation in workers' compensation is when a case is determined to be workers' compensation and the health benefits plan has already paid for the service and is requesting the workers' compensation carrier or the provider to refund the money that the plan paid on behalf of the worker.
- (u) "Technical surgical assist" means that additional payment for an assistant surgeon, referenced in R 418.10416, is allowed for certain designated surgical procedures. The Health Care Services Manual, published annually by the workers' compensation agency, denotes a surgical procedure allowing payment for the technical surgical assist with the letter "T."
- (v) "Treatment plan" means a plan of care for restorative physical treatment services that indicates the diagnosis and anticipated goals.
- (w) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges which were previously billed separately and which are included in the package for that procedure as defined by these rules. A usual and customary charge for a procedure shall be calculated based on data beginning January 1, 2000.

R 418.10117 Carrier responsibilities.

- Rule 117. (1) The carrier or its designated agent shall assure that a billing form is completed properly before making payment to the licensed provider or licensed facility.
- (2) A carrier may designate a third party to receive provider bills on its behalf. If a carrier instructs the provider to send the medical bills directly to the third party, then the

30-day limit of this rule begins when the third party receives the bill. The carrier is responsible for forwarding bills and medical documentation when there is a third party reviewing medical bills for the carrier.

(3) A carrier or designated agent shall make payment of an unadjusted and properly submitted bill within 30 days of receipt of a properly submitted bill or shall add a self-assessed 3% late penalty to the maximum allowable payment or the provider's charge, whichever is less, as required by these rules.

(4) A carrier or designated agent shall record payment decisions on a form entitled "The Carrier's Explanation of Benefits" using a format approved by the workers' compensation agency. The carrier or designated agent shall keep a copy of the explanation of benefits and shall send a copy to the provider and to the injured worker. The carrier's explanation of benefits shall list a clear reason for the payment adjustment or amount disputed and shall notify the provider what information is required for additional payment.

(5) A carrier or designated agent shall make payment of an adjusted bill or portion of an adjusted bill within 30 days of receipt of the properly submitted bill. If a carrier or designated agent rejects a bill in its entirety, then the carrier or designated agent shall notify the provider of the rejection within 30 days after receipt of a properly submitted bill.

(6) If a carrier requests the provider to send duplicated copies of the documentation required in part 9 or additional medical records not required by these rules, then the carrier shall reimburse the provider for the copying charges in accord with R 418.10118.

(7) When the carrier has disputed a case and has not issued a copy of the formal notice of dispute to the medical provider, then the carrier's explanation of benefits shall be sent in response to the provider's initial bill. The carriers' explanation of benefits shall serve as notice to the provider that nonpayment of the bill is due to the dispute.

R 418.10212 Physical and occupational therapy; physical medicine services.

Rule 212. (1) For the purposes of workers' compensation, physical medicine services, procedure codes 97010-97799, shall be referred to as "physical treatment" when the services are provided by a practitioner other than a physical therapist or an occupational therapist. Physical therapy means physical treatment provided by a licensed physical therapist. Occupational therapy means physical treatment provided by an occupational therapist.

(2) Physical medicine services shall be restorative. If documentation does not support the restorative nature of the treatment, then the service shall not be reimbursed.

(3) Any of the following may provide physical treatment, to the extent that licensure, registration, or certification law allows:

A doctor of medicine.

A doctor of osteopathic medicine and surgery.

(c) A doctor of dental surgery.

(d) A doctor of chiropractic.

(e) A doctor of podiatric medicine and surgery.

(f) A physical therapist.

(g) An occupational therapist.

(4) Only a licensed physical therapist, registered occupational therapist, or licensed practitioner may use procedure codes 97001-97004 to describe the physical medicine and rehabilitation evaluation services. Job-site evaluations may be paid to a registered occupational therapist, a licensed physical therapist, or a physician. Job-site evaluations for workers' compensation are by report and are described on the bill using codes WC500-WC600.

(5) If a practitioner performs and bills for physical treatment, then the practitioner shall do all of the following:

- (a) Perform an initial evaluation.
- (b) Develop a treatment plan.
- (c) Modify the treatment as necessary.
- (d) Perform a discharge evaluation.

The practitioner shall provide the carrier with an initial evaluation and a progress report every 30 calendar days and at discharge. Documentation requirements are the same as the requirements in R 418.10204(2).

(6) A provider shall report procedure code 97750 to describe a functional capacity evaluation. The carrier shall reimburse a maximum of 24 units or 6 hours for the initial evaluation. Not more than 4 additional units shall be billed for a re-evaluation occurring within 2 months.

(7) Physical medicine modalities are those agents applied to produce therapeutic changes to tissue and include, but are not limited to, thermal, acoustic, light, mechanical or electric energy. Both of the following apply:

(a) Supervised modalities include procedure codes 97010-97028. These codes do not require direct 1-on-1 patient contact by the provider. These modalities shall be performed in conjunction with a therapeutic procedure including manipulative services or the modalities shall not be reimbursed.

(b) Constant attendance modalities are those procedure codes 97032-97039 that require direct 1-on-1 patient contact by the provider.

(8) Therapeutic procedure codes 97110-97546 are procedures that effect change through the application of clinical skills and services that attempt to improve function. The physician or therapist shall have direct 1-on-1 patient contact.

(9) The following provisions apply to the listed modality services:

(a) Whirlpool shall only be reimbursed when done for debridement or as part of a restorative physical treatment program.

(b) Procedure 97010 is a bundled procedure code and shall not be reimbursed separately.

(c) Not more than 1 deep heat procedure shall be billed on the same date of service for the same diagnosis. Deep heat procedures include diathermy, microwave, ultrasound, and phonophoresis.

(d) Phonophoresis shall be billed using procedure code 97035 with modifier code -22 and shall be reimbursed at the same rate as procedure code 97035, plus \$2.00 for the active ingredient used in the process.

(e) Iontophoresis shall include the solution, medication, and the electrodes.

(f) Electrical stimulation shall include the electrodes.

(g) Procedure codes 97032, 97033, and 97035 shall not be reimbursed to a doctor of chiropractic.

(h) Fluidotherapy, a dry whirlpool treatment, shall be reported using code 97022.

R 418.10213 Rescinded.

R 418.10214 Orthotic and prosthetic equipment.

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

- (a) A doctor of medicine.
 - (b) A doctor of osteopathic medicine and surgery.
 - (c) A doctor of chiropractic.
 - (d) A doctor of podiatric medicine and surgery.
- (2) Orthotic equipment may be any of the following:

- (a) Custom-fit.
- (b) Custom-fabricated.
- (c) Non-custom supply that is prefabricated or off-the-shelf.

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

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

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

(7) The health care services division shall publish the maximum allowable payments for L-code procedures in the manual 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."

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

R 418.10905 Billing for physical and occupational therapy.

Rule 905. (1) A physical or occupational therapist shall bill procedure codes 97001-97799. A registered occupational therapist or licensed physical therapist in independent practice shall place his or her signature and license or certification number on the bill.

(2) Only a physician, registered occupational therapist, or a licensed physical therapist shall bill for job site evaluation or treatment. The reimbursement for these procedures shall be contractual between the carrier and provider and shall be billed as listed in the following table:

Code	Descriptor
WC500	Job site evaluation; patient specific, initial 60 minutes
WC505	each additional 30 minutes, by contractual agreement
WC550	Job site treatment; patient specific, initial 60 minutes
WC555	each additional 30 minutes, by contractual agreement
WC600	Mileage for job site evaluation or job site treatment per mile

(3) Procedures 97760 and 97761 shall only be reimbursed when billed by a registered occupational or licensed physical therapist.

(4) Only a licensed or registered physical or occupational therapist shall bill for work hardening services, “by report” or “BR,” procedure codes 97545 and 97546.

R 418.101002a Conversion factor for practitioner services.

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

(2) The conversion factor for medicine, radiology, and surgical procedures shall be \$50.70 for the year 2009 and shall be effective for dates of service on the effective date of these rules.

R 418.101003 Reimbursement for “by report” and ancillary procedures.

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

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

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

(3) Orthotic and prosthetic procedures, L0000-L9999, shall be reimbursed by the carrier at Medicare plus 5%. The health care services division shall publish maximum allowable payments for L-code procedures in the manual separate from these rules. Orthotic and prosthetic procedures not included in the manual shall be considered by report procedures and require a written description accompanying the charges on the CMS-1500 claim form. The report shall include date of service, a description of the services(s) provided, the time involved, and the charge for materials and components.

R 418.101006 Reimbursement for mental health services.

Rule 1006. (1) A carrier shall only reimburse procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, 90862, 90865, and 90870 when billed by a psychiatrist (an M.D. or D.O).

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

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

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

(a) -AL limited license psychologist.

(b) -AJ certified social worker.

(c) -LC licensed professional counselor.

(d) -MF licensed marriage and family therapist.

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

(a) -CS limited licensed counselor.

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

R 418.101016 Reimbursement; payment ratio methodology.

Rule 1016. (1) A hospital licensed in Michigan billing facility services shall be reimbursed using the maximum payment ratio methodology for the following services:

Inpatient or observation care.

Emergency department services.

(c) Occupational, physical, and speech therapy services.

(d) Outpatient surgeries.

(e) Laboratory services and outpatient services.

If a carrier pays a properly submitted bill or unadjusted portion of the bill within 30 days of receipt, then the payment is calculated by multiplying the charges times the hospital's

maximum payment ratio times a multiplier of 107%. If a carrier pays the bill after 30 days, then the multiplier shall be 110% allowing for a 3% late fee.

(2) When a hospital outside the state of Michigan submits a bill for facility services, the carrier may initially process payment by using the method described in subrule (1) of this rule, applying the average maximum payment ratio, as published in the health care services manual. If the facility located outside of Michigan does not accept reimbursement according to Michigan health care services rules, then the carrier shall negotiate the charges with the out-of-state facility or reimburse the facility according to the laws of the state where the facility is located.

(3) If applying the ratio methodology results in an amount greater than the hospital's charge, the carrier shall reimburse the hospital's charge. The only time a carrier shall pay in excess of the charge is if a properly submitted bill was not paid within 30 days and, in that instance, the carrier shall reimburse the charge plus a 3% late fee.

(4) Observation care shall not be for more than 24 hours. If the patient does not meet admission criteria according to the length of stay guidelines, then the patient shall be discharged from observation care.

R 418.101504 Rescinded.