

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

WORKERS' COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

Filed with the Secretary of State on September 15, 2015

These rules become effective immediately upon filing with the Secretary of State.

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

R 418.10904, R 418.10915, R 418.10922, R 418.10923, R 418.101007, R 418.101008, R 418.101015, and R 418.101208 of the Michigan Administrative Code are amended.

PART 9. BILLING

SUBPART A. PRACTITIONER BILLING

R 418.10904 Procedure codes and modifiers.

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

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

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

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

- (a) Description of the service.

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

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

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

Table 10904 Modifier Codes

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

R 418.10915 Billing for anesthesia services.

Rule 915. (1) Anesthesia services shall consist of 2 components. The 2 components are base units and time units. Each anesthesia procedure code is assigned a value for reporting the base units. The base units for an anesthesia procedure shall be as specified in the publication entitled "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107. The anesthesia codes, base units, and instructions for billing the anesthesia service shall be published separate from these rules in the health care services manual.

(2) An anesthesia service may be administered by either an anesthesiologist, anesthesia resident, a certified registered nurse anesthetist, or a combination of a certified registered nurse anesthetist or a certified anesthesiologist assistant, and a physician providing medical direction or supervision. When billing for both the anesthesiologist and a certified registered

nurse anesthetist or a certified anesthesiologist assistant, the anesthesia procedure code shall be listed on 2 lines of the CMS 1500 with the appropriate modifier on each line.

(3) One of the following modifiers shall be added to the anesthesia procedure code to determine the appropriate payment for the time units:

(a) Modifier -AA indicates the anesthesia service is administered by the anesthesiologist.

(b) Modifier -QK indicates the anesthesiologist has provided medical direction for a certified registered nurse anesthetist, CRNA, certified anesthesiologist assistant (AA), or resident. The CRNA, AA, or resident may be employed by a hospital, the anesthesiologist, or may be self-employed.

(c) Modifier -QX indicates the certified registered nurse anesthetist or certified anesthesiologist assistant has administered the procedure under the medical direction of the anesthesiologist.

(d) Modifier -QZ indicates the certified registered nurse anesthetist has administered the complete anesthesia service without medical direction of an anesthesiologist.

(4) Total anesthesia units shall be calculated by adding the anesthesia base units to the anesthesia time units.

(5) Anesthesia services may be administered by any of the following:

(a) A licensed doctor of dental surgery.

(b) A licensed doctor of medicine.

(c) A licensed doctor of osteopathy.

(d) A licensed doctor of podiatry.

(e) A certified registered nurse anesthetist.

(f) A licensed anesthesiology resident.

(g) A certified anesthesiologist assistant.

(6) If a surgeon provides the anesthesia service, the surgeon shall only be reimbursed the base units for the anesthesia procedure.

(7) If a provider bills physical status modifiers, then documentation shall be included with the bill to support the additional risk factors. When billed, the physical status modifiers are assigned unit values as defined in the following Anesthesiology Physical Status Modifiers Unit Value table:

P1: A normal healthy patient = 0

P2: A patient who has a mild systemic disease = 0

P3: A patient who has a severe systemic disease = 1

P4: A patient who has a 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

(8) Procedure code 99140 shall be billed as an add-on procedure if an emergency condition, as defined in R 418.10108, complicates anesthesia. Procedure code 99140 shall be assigned 2 anesthesia units. Documentation supporting the emergency shall be attached to the bill.

(9) If a pre-anesthesia evaluation is performed and surgery is not subsequently performed, then the service shall be reported as an evaluation and management service.

R 418.10922 Hospital billing instructions.

Rule 922. (1) A hospital shall bill facility charges on the UB-04 national uniform billing claim form and shall include revenue codes, ICD-9-CM coding, until ICD-10-CM is implemented, then ICD-10-CM coding, HCPCS codes, and CPT® procedure codes to identify the surgical, radiological, laboratory, medicine, and evaluation and management services. This rule only requires that the following medical records be attached when appropriate:

(a) Emergency room report.

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

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

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

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

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

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

R 418.10923 Hospital billing for practitioner services.

Rule 923. (1) A hospital billing for practitioner services, including a certified registered nurse anesthetist, a certified anesthesiologist assistant, a physician, a nurse who has a specialty certification, and a physician's assistant, shall submit bills on a CMS 1500 form and the hospital shall use the appropriate procedure codes adopted by these rules. A hospital shall bill for professional services provided in the hospital clinic setting as practitioner services on a CMS 1500 form using outpatient hospital for the site of service. A hospital or hospital system-owned office practice shall bill all office services as practitioner services on a CMS 1500 form using office or clinic for the site of service. A hospital or hospital system-owned industrial or occupational clinic providing occupational health services for injured workers shall bill all clinic services as practitioner services on a CMS 1500 using office or clinic for the site of service. A hospital or hospital system-owned industrial or occupational clinic shall not use emergency department evaluation and management procedure codes. Radiology and laboratory services may be billed as facility services on the UB-04.

(2) A hospital billing for the professional component of a medical service, excluding physical medicine, occupational medicine, or speech and hearing services shall bill the service on a CMS 1500 claim form adding modifier -26 identifying the bill is for the professional component of the service. The bill shall indicate outpatient hospital for the site of service. The carrier shall pay the maximum allowable fee listed in the manual for the professional component of the procedure. If the professional component is not listed, then the carrier shall pay 40% of the maximum allowable fee.

(3) A hospital billing for a radiologist's or pathologist's services shall bill the professional component of the procedure on the CMS 1500 claim form and shall place modifier -26 after the appropriate procedure code to identify the professional component of the service. The carrier shall pay the maximum allowable fee listed in the manual for the professional component of the procedure. If the professional component is not listed, then the carrier shall pay 40% of the maximum allowable fee.

(4) A hospital billing for a certified registered nurse anesthetist or certified anesthesiologist assistant shall bill only time units of an anesthesiology procedure and use modifier -QX with the appropriate anesthesia code, except when billing for a certified registered nurse anesthetist in the absence of medical direction from a supervising anesthesiologist.

PART 10. REIMBURSEMENT

SUBPART A. PRACTITIONER REIMBURSEMENT

R 418.101007 Reimbursement for anesthesia services.

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

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

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

- (a) Increments of 15 minutes or portions thereof, for administration of the anesthesia.
- (b) Increments of 30 minutes or portions thereof, for supervision of a CRNA or certified anesthesiologist assistant.
- (c) In no instance shall less than 1 time unit be reimbursed.

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

- (a) If the anesthesiologist administers the anesthesia, then the modifier shall be -AA and the maximum payment shall be \$2.80 per minute.
- (b) If the anesthesiologist supervises a CRNA or certified anesthesiologist assistant, then the modifier shall be QK and the maximum payment shall be \$1.40 per minute.
- (c) If a CRNA or a certified anesthesiologist assistant supervised by an anesthesiologist administers the anesthesia, then the modifier shall be -QX and the maximum payment shall be \$2.80 per minute.
- (d) If a CRNA administers without supervision of the anesthesiologist, then the modifier shall be -QZ and the maximum payment shall be \$2.80 per minute.

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

Rule 1008. (1) For purposes of these rules, chronic pain is pain unrelated to cancer or is incident to surgery and that persists beyond the period of expected healing after an acute

injury episode. It is pain that persists beyond 90 days following the onset of the pain. The payer shall reimburse for opioids used in the treatment of chronic pain resulting from work-related conditions.

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

- (a) Injury dates on or after June 26, 2015.
- (b) Beginning December 26, 2015, all other injury dates.

R 418.101015 General rules for facility reimbursement.

Rule 1015. (1) A facility licensed by this state shall receive the maximum allowable payment in accordance with these rules. The facility shall follow the process specified in these rules for resolving differences with a carrier regarding payment for the appropriate health care services rendered to an injured worker.

(2) The carrier or its designated agent shall assure that the UB-04 national uniform billing claim form is completed correctly before payment. A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.

(3) A carrier shall pay, adjust, or reject a properly submitted bill within 30 days of receipt, sending notice on a form entitled "Carrier's Explanation of Benefits" in a format specified by the agency. The carrier shall reimburse the facility a 3% late fee if more than 30 days elapse between a carrier's receipt of a properly submitted bill and a carrier's mailing of the payment.

(4) Submission of a correctly completed UB-04 claim form shall be considered to be a properly submitted bill. The following medical records shall also be attached to the facility charges as applicable:

- (a) Emergency room report.
- (b) The initial evaluations and progress reports every 30 days whenever physical medicine, speech, and hearing services are billed by a facility.
- (c) The anesthesia record whenever the facility bills for the services of a CRNA, certified anesthesiologist assistant, or anesthesiologist.
- (5) Additional records not listed in subrule (4) of this rule may be requested by the carrier and shall be reimbursed in accordance with R 418.10118.

PART 12. Carrier's professional health care review program

R 418.101208 Renewal of certification.

Rule 1208. (1) A carrier or other entity shall apply to the workers' compensation agency for renewal of certification in the manner prescribed by the agency, submitting the application within 90 days before the expiration date on the certification.

(2) A carrier or other entity shall receive renewal of certification upon receipt of an updated description of its program as specified in R 418.101206.