

**State of Michigan
Workers'
Compensation**

**Agency
Resolution,
Rehabilitation &
Rules Division**

UPDATE

**Health Care Services Rules &
Fee Schedule**

Effective 12/26/2014

HEALTH CARE SERVICES RULES

- Health Care Services Rules are the promulgated rules governing health care services under the Michigan Workers' Disability Compensation Act of 1969.
- Health Care Services Rules can be identified by the R418. distinction.

HEALTH CARE SERVICES MANUAL

- Is designed to be user friendly.
- Any reference in the manual to “MCL418” relates to the Michigan Workers’ Disability Compensation Act statutory language.
- Any conflicts between the language of the manual and the rules, the language of the rules control.

WC-104B FORM

- The WC-104B form was revised as of 09/2013.
- **EVERYONE** should be using this version.
- It is available on our website:
www.michigan.gov/wca

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APPLICATION FOR MEDIATION OR HEARING – FORM B

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

hereby certify that we have complied with Rules 1801 through 1806 and Parts B and 10 of the Workers' Compensation Health Care Benefits Rules

Submitted on behalf of: Health Care Provider Insurance Company Self-Insured Employer

EMPLOYEE IDENTIFICATION

1. Employee Name (Last, First, MI)		2. Social Security Number		3. Date of Birth		4. Date of Injury	
5. Street Address		6. City		7. State		8. ZIP Code	
						9. County of Injury	

EMPLOYER IDENTIFICATION

10. Employer Name			11. Federal I.D. Number		
12. Street Address		13. City		14. State	
				15. ZIP Code	
16. Contact Person			17. Telephone Number		

CARRIER IDENTIFICATION

18. Carrier or Self-Insured Name			19. NAIC or Self-Insured Number		
20. Street Address		21. City		22. State	
				23. ZIP Code	
24. Claim Handler			25. Claim Number		26. Telephone Number

HEALTH CARE PROVIDER IDENTIFICATION

27. Provider Name				28. License, Registration, or Certification Number	
29. Street Address		30. City		31. State	
				32. ZIP Code	
33. Date of Service	Amount of Bill	Date of 1 st Billing	Date of 2 nd Billing	Late Fee Requested	Reason for Filing (see codes on reverse)

34. If the worker involved in this case is currently being denied treatment as a result of this dispute, check the box on the left and provide a description of the needed treatment that is being denied in the box on the back.

35. If the carrier is currently paying for medical benefits pursuant to an order and this is a petition to stop such payment, check the box on the left and attach a copy of the order.

By signing this form, I certify that the information included on this form is true, correct and complete to the best of my knowledge. I understand that making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

36. Applicant Name		37. Telephone Number		38. Applicant Email Address	
39. Applicant Signature				40. Date	

41. Name of Attorney (if applicable)		42. Attorney I.D.		43. Attorney Telephone Number	
44. Attorney Signature					

104B Information that needs to be accurate.

- Employee name.
- Full social security number.
- Employee date of birth.
- Employer information.
- Date of Injury.
- Name of the insurance company, if one is being billed.

What does “Claim” mean to you?

- Health care provider: A claim is the bill that is submitted to the carrier for services rendered to the injured worker.
- Carrier: A “claim” is the file set up to investigate the alleged injury and pay appropriate benefits if owed.

Withdrawing a 104B

- Sign the bottom of the hearing notice.
- Fax ONLY the signed hearing notice.
- **DO NOT SEND A COVER SHEET, LETTER, COPY OF THE 104B.**
- Do not highlight on the 104B.

Difference between a litigated case and a disputed case.

- **Litigated case:**
- 104A has been filed
- Injured worker is pursuing their claim through litigation.
- **Disputed case:**
- WC-107, Notice of Dispute has been filed by the carrier.
- If the injured worker does not file a 104A, then in the eyes of the State, the dispute stands.

What to do if the case is in litigation.

- * If there are outstanding bills, file a 104B.
- * Send copies of outstanding bills to the injured worker and their attorney.
- * Obtain a copy of the Notice of Dispute.
- * Submit the bills to the injured workers health insurance.

OUT OF STATE PROVIDERS

- * Out of state providers may or may not accept the MAP made in accordance with the Michigan Fee Schedule.
- * If an out of state facility refuses to negotiate fees, the carrier must reimburse the facility according to the laws of the state where they are located and services were performed. (R418.3101016(2))

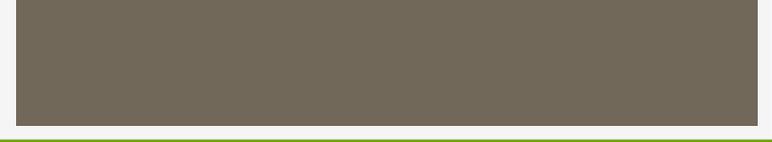
COPY FEES

.45 cents per page plus the actual cost of mailing.

Administrative charge for retrieval & copying: 1-15 minutes \$2.50. Each additional 15 minute increment \$2.50.

Must specify the date of injury.

The party who requests the records shall pay the copying charge.



The copying charge for each x-ray film, requested by the carrier or the carrier's agent shall be reimbursed at \$15.00, which includes mailing and handling.

R418.10118

- Subpoenaed records are not subject to the Health Care Services copy fees.

Requests for existing records and reports

For special reports up to 3 pages in length, the carrier shall reimburse the provider at \$25.00 per page.

Complex reports greater than 3 pages, shall be reimbursed on a contractual basis between the carrier and the provider.

R418.10114

Rehabilitation nurse or nurse case manager visit

(2) The provider may bill the rehabilitation nurse or nurse case manager visit in addition to the evaluation and management service using code RN001.

The carrier shall reimburse the provider \$25.00 for RN001.

R418.10121

MEDICAL HISTORY

- 1) The initial medical history obtained is most important information that will be reviewed by the adjuster and magistrates.
- 2) It is imperative that the medical histories taken be **ACCURATE.**

NDC NUMBERS

There are now two approved sources from which to obtain NDC numbers.

- 1) Red Book Online subscription service of Truven Health Analytics:
<http://www.redbook.com/redbook/online>
- 2) Medi-Span Drug Information Database, a part of Wolters Kluwer Health: <http://www.medispn.com>

ICD-9 vs ICD-10

Hospital billing instructions

A hospital shall bill facility charges on the UB-04 national uniform billing claim form and shall include revenue codes, ICD-9 coding until ICD-10 is implemented. Then ICD-10 is to be used.

R418.10922

“Biologics” or “Biologicals”

Include drugs or other products that are derived from life forms. Biologics are biology-based products used to prevent, diagnose, treat, or cure disease or other conditions in humans and animals. Biologics generally include products such as vaccines, blood, blood components, allergenics, somatic cells, genes, proteins, DNA, tissues, skin substitutes, recombinant therapeutic proteins, microorganisms, antibodies, immunoglobulins, and others, including those that produced using biotechnology and are made from proteins, genes, antibodies and nucleic acids, etc.

R418.10108(f)

“Custom Compound”

As used in these rules, means a customized topical medication prescribed or ordered by a duly licensed prescriber for the specific patient that is prepared in a pharmacy by a licensed pharmacist in response to a licensed practitioner’s prescription by order, by combining, mixing, or alter of ingredients, but not reconstituting, to meet the unique needs of an individual patient.

R418.10108(n)

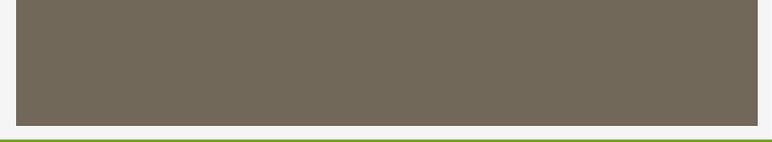
“Opioid Drugs”

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

R418.10109(i)

R418.101008 Reimbursement of opioid treatment for chronic, non-cancer pain.

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



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

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

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

R418-101008a Reimbursement of opioid treatment for chronic, non-cancer pain.

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



(a) A review and analysis of the relevant prior medical history, including any consultations that have been obtained, and a review of data received from an automated prescription drug monitoring program in the treating jurisdiction, such as the Michigan Automated Prescription System (MAPS), for identification of past history of narcotic use and any concurrent prescriptions.



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

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

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

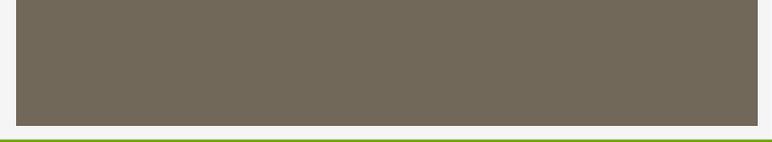
(e) A treatment plan which includes all of the following:

- (i) Overall treatment goals and functional progress.
- (ii) Periodic urine screens.
- (iii) A conscientious effort to reduce pain through the use of non-opioid medications, alternative non-pharmaceutical strategies of both.
- (iv) Consideration of weaning the injured worker from opioid use.



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

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



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

R418.101008b Denial of reimbursement for prescribing and dispensing opioid medications use to treat chronic, non-cancer pain.

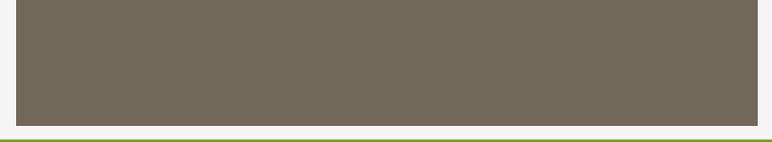
*Reimbursement for prescribing and dispensing opioid medications may be denied, pursuant to the act. Denial of reimbursement may occur if the physician reporting and treatment plan requirements as stated in R418.101008a are not met.

*Denial of reimbursement shall occur only after a reasonable period of time is provided for the weaning of the injured work from the opioid medications and alternative means of pain management have been offered.

R418-101009 Reimbursement for custom compound topical medication.

(1) 6 months after the effective date of this rule, a custom compound topical medication, as defined in R418.10108, shall be reimbursed only when the compound meets all of the following standards:

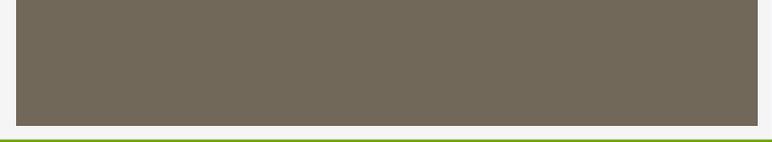
- (a) There is no readily available commercially manufactured equivalent product.
- (b) No other FDA approved alternative drug is appropriate for the patient.
- (c) The active ingredients of the compound each had an NDC number and are components of drugs approved by the United States Food and Drug Administration (FDA).



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

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

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



The provider shall dispense a 30-day supply per prescription

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

Rule 418.10207 Mental Health Services

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

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

Rule 418.10504 Radiology, Radiation Therapy and Nuclear Medicine.

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

The agency shall publish in a manual separate from these rules a table listing **the diagnostic imaging CPT codes subject to the multiple procedure payment reduction.** When more than 1 procedure from **the table** is **furnished to the same patient, on the same day, in the same session, by the same Physician or group practice, the procedure with the highest relative value** is paid at 100% of the maximum allowable payment.

Each additional procedure shall have a modifier -51 appended and the technical component shall be reduced to **50%** of the maximum allowable payment, or the provider's charge, whichever is less, **and the professional component shall be reduced to 75% of the maximum allowable payment, or the provider's charge, whichever is less.**

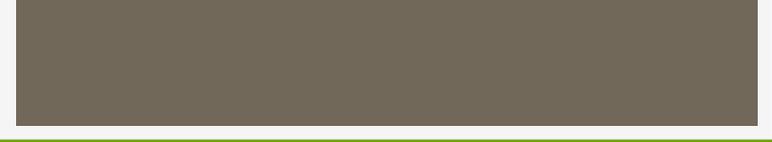
Rule 418.10902 Billing for injectable medications, other than vaccines and toxoids in the office setting.

(4) The carrier shall reimburse the medication **at average wholesale price (AWP) minus 10%**, as determined by Red Book or Medi-Span, as adopted by reference in R418.10107.

No dispensing fee shall be billed for injectable medications administered in the office setting.

R418.1902a Billing for vaccines and toxoids in office setting.

(1) When a provider administers a vaccine or toxoid in the office setting, both vaccine and toxoid shall be billed as separate services. If a significantly separate evaluation and management service is performed, the appropriate evaluation and management service code shall be reported in addition to the vaccine or toxoid administration code pursuant to CPT codebook guidelines, as adopted by reference in R418.10107.



(2) The vaccine or toxoid being administered and the administration of the vaccine or toxoid shall be billed using the applicable CPT procedure codes pursuant to CPT codebook guidelines, as adopted by reference in R418.10107.

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

(4) The carrier shall reimburse the vaccine or toxoid at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span, as adopted by reference in R418.310107. No dispensing fees shall be billed for vaccines or toxoids administered in the office setting.

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

R418.101003a Reimbursement of dispensed medication.

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

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

R418.101003b Reimbursement for biologicals, durable medical equipment, and supplies.

- (1) The carrier shall reimburse durable medical equipment (DME), supplies **and biologicals** at Medicare plus 5%. The health care services division shall provide maximum allowable payments for DME, supplies **and biologicals** separate from these rules on the agency website. **Biologicals that have NDC numbers shall be billed and reimbursed under R418.10912.**
- (2) DME is only billed with a 99070 CPT code if there is no applicable HCPCS code.

Extended Office Visit

CPT does allow for extended office visits.

Documentation is of the utmost importance when billing for an extended office visit.

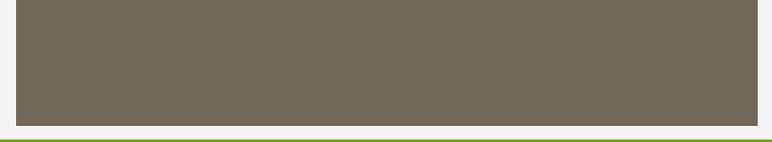
If the documentation does not support it, the charge will be denied.

What are bill reviewers looking for in the documentation?

- Nature of the presenting problem.
- Diagnostic codes used on the billing.
- Time spent. Is it correct for what is billed.
- Should the provider be billing at a higher E/M code that allows more time?
- What are they doing during that extra time?
Counseling? Coordination of care?
- Is there documentation?
- Time codes: unit of time is obtained when the mid point is passed.

Voicemail messages for facilitators

- * Injured employees name
- * At least the last four digits of the Social Security Number.
- * Date and time of hearing, if known.



The Workers' Compensation Agency does not handle individual claims, pay bills, authorize treatment or issue checks.

AGENCY CONTACTS

Angie Lewis, Facilitator 517-322-5755

LewisA1@michigan.gov

Kathy Witchell, Facilitator 517-322-4971

witchellk@michigan.gov

Kris Kloc, HCS Analyst 517-636-7805

KlocK@michigan.gov

David Campbell, Manager 517-322-1721

CampbellD5@michigan.gov

Insurance Coverage: 517-322-1195

Fax: 517-636-5484

www.michigan.gov/wca