LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

2015 HEALTH CARE SERVICES MANUAL

Effective December 26, 2014

2015

Chapter 1

Overview and Guidelines

Introduction

The Health Care Services Policy Manual contains information regarding health care 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 (HCS) Rules, referenced using the designation **"R418". This manual is only a guide for implementation of the rules.** Any reference in the manual to **"MCL418"** relates to Michigan Workers' Disability Compensation Act statutory language. **If there are any conflicts between the language of the manual and the rules, the language of the rules shall control.**

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 the 2014 HCPCS Level II Code book.

Facility 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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Copyright Notice

Procedure codes found in this manual are from the 2014 edition of "Current Procedural Terminology (CPT®) Professional Edition" published by the American Medical Association (AMA). All rights reserved. **Refer to "*Current Procedural Terminology (CPT®) 2014 Professional Edition*" for procedure code descriptions.**

No fee schedules, relative value units (RVU's) or conversion factors are included in the CPT codebook. The AMA assumes no responsibility for the consequences attributed to or related to any use or interpretation of any information contained or not contained in this product. The AMA does not directly or indirectly practice medicine nor dispense medical services. The AMA assumes no liability for the data contained herein.

The 2014 Michigan RBRVS Fee Schedule utilizes 2014 October release CMS Fee Schedule data.

Providers Covered by the Rules

All providers of health care services must be licensed, registered or certified as defined in the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

Services Listed in the Manual

The State of Michigan workers' compensation maximum allowable payments (MAP) for medical services are found using the worksheet and data source described in pages 3-4 of 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 MAP worksheet and data source described in pages 3-4 of this manual list the CPT code, the Relative Value Unit (RVU), and the MAP. Follow-up days for surgical procedures and practitioner payments for the Ambulatory Surgical Center (ASC) /Freestanding Surgery Outpatient Facility (FSOF) are discussed in the Chapter 8 surgery section of this manual. Payment indicators for pass through items, implants, drugs and biologicals in an ASC/FSOF are referenced on the website in the worksheet under the ASC tab and discussed in Chapter 15 of this manual. **Except where otherwise noted in this manual, billing instructions listed in the "Current Procedural Terminology (CPT®) 2014 Professional Edition" shall apply.**

All necessary billing/payment information is provided at the WCA website: www.michigan.gov/wca, Health Care Services tab. There, you will find:

2015 Rules, Manual & Fees

The Health Care Services cost containment calculations for the 2015 Rule Set are posted below. The boxes below address the six different methods of calculation used to determine the maximum allowable payment (MAP) for medical care, treatment, procedures and devices under the Michigan Workers' Compensation Act and the Health Care Services Rules.

Within each box, there are two buttons. Clicking on the Worksheet button will take the user to a calculation worksheet where the appropriate CPT or HCPCS code is entered into the specific shaded box. Upon entering, the worksheet will automatically calculate the specific fee for the code. By clicking the methodology button, the user will be presented with a more detailed explanation of how the payment amount is calculated, and the specific rules governing these calculations.

The 2014 October release CMS Physicians Fee Schedule is the underlying data source for all the RBRVS based calculations.

Questions may be directed to 1-517-284-8900.

2015 HCS Rules | 2015 HCS Manual

AMBULATORY SURGICAL CENTER
Drugs & Biologicals, Pass-Through Items; Surgery
Worksheet | Methodology

ANESTHESIA
Worksheet | Methodology

CLINICAL LAB
Worksheet | Methodology

HCPCS LEVEL II
Durable Medical Equipment; Orthotic/Prosthetic
Worksheet | Methodology

HOSPITAL RATIOS
Excel | Methodology

RBRVS
Evaluation & Management; Medicine; Physical Medicine; Pathology; Radiology; Surgery
Worksheet | Methodology

By clicking on the Worksheet link, the user will be presented with a spreadsheet that will calculate the MAP for a given code using the methodology for that particular payment group such as labs, anesthesia, etc. The appropriate CPT or HCPCS code is entered

into the specified shaded box on the spreadsheet by the user. Once entered, the correct MAP will be automatically calculated. Each worksheet provides a link to the CMS (Center for Medicare & Medicaid Services) specific fee schedule which serves as the data source for the worksheet. A copy of the full CMS Physicians Fee Schedule is posted on our website.

By clicking the Methodology link, the user will be presented with a more detailed explanation of how the payment amount is calculated, as well as the specific rules governing the relative calculations and reimbursement procedures.

The RBRVS worksheet data source link takes the user to a WCA modified version of the CMS Physician Fee Schedule. The WCA version is smaller but does include all the CMS list of codes. The WCA version eliminates many columns that do not apply to WCA calculations. The two color coded columns in the RBRVS spreadsheet correspond to the worksheet Facility or Non-facility color coding for ease of use. There is also a link to the full CMS spreadsheet that can be used for verification of the data in the WCA version of the chart if necessary.

Once the desired worksheet is viewed, it is suggested that the worksheet be downloaded to the individual users' computer for easier access. The tables will not change until the annual rule revision.

Where applicable, the worksheets will include both a facility and non-facility site of service MAP for practitioner reimbursement. Specific reimbursement information will be found in the methodology link for each worksheet and data source described in pages 3-4 of this manual. 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: **RBRVS**

The maximum allowable payments in this manual are based upon the CMS resource-based relative value scale (RBRVS) payment schedule. 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 physician work, practice expense, and professional liability insurance involved in providing each service, and applying specific geographical indices (GPCI) to determine the 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	1.006
Malpractice	1.3474
Practice Expense	.9742

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

Adjusted Work RVU (Work RVU x 1.006) + Adjusted MP RVU (MP RVU x 1.3474) + Adjusted PE RVU (PE RVU x .9742) = Michigan Total RVU

The MAP amounts in Chapters 6-13 (except for anesthesia services) are calculated using the worksheet and data source described in pages 3-4 of this manual. The MAP amounts are determined by multiplying the Michigan Total RVU times the conversion factor. The conversion factor for the CPT procedure codes is found in R418.101002.

Determining Payment

The MAP amounts provided by the worksheets represent the maximum allowable payments that a provider can be paid for rendering services under the state of Michigan Workers' Disability 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 MAP and shall not balance bill the worker (Refer to R 418.10105).

By Report (BR) Services

When a procedure code, listed in the "HCPCS 2014 Level II Professional Edition" or "Current Procedural Terminology (CPT®) 2014 Professional Edition" 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, as defined in R418.10109, whichever is less.

Codes Not Listed in the Worksheet, Methodology or Related Table(s)

Every effort has been made to include all of the CPT codes and the assigned RVUs in this manual and on the WCA website. Inclusion of the CPT code in the manual or on the WCA website 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 worksheet, methodology or related table but is listed in either the CPT codebook or HCPCS book, as referenced in R418.10107, 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) R 418.10101(2)

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 IME to determine the medical aspects of the case. This examination would be billed with the evaluation code that most accurately reflects the service rendered.

CPT consultation codes 99241-99245 and 99251-99255 are no longer payable.

Claim Filing Limitation_R418.10102

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.

The Workers' Compensation Agency (WCA) does not pay or review bills. Disputes regarding medical bill payment may be brought before the Workers' Compensation Agency by filing form WC-104B, Application for Mediation or Hearing. The State of Michigan Workers' Compensation HCS Rules discuss this information in R 418.101301, R 418.101302 and R 418.101303.

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 28 days. **After 28 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 as stated** in MCL418.315(1). 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

Pursuant to MCL418.315 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 28 days of care for the injury or illness and report the injury to their workers' compensation carrier.

The insured employer must promptly file with the WCA the Form WC-100, "Employer's Basic Report of Injury" reporting cases when the injury results in seven 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 (HCS) 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 as a duplicate bill) to the carrier and add a 3% late fee. R418.10116.

The provider may file an "Application for Mediation and Hearing," (WC-104B) for unresolved claims (See Part 13 of the HCS rules and Chapter 4 of this manual) when:

- The provider has sent two 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 allowable payment (MAP) established by the HCS Rules, or the carrier has disputed utilization of the overall services. If the issues are not resolved through the reconsideration process, the provider may file a WC-104B.
- When the worker contests a carrier's dispute and the case becomes contested or litigated (worker files WC-104A with the WCA for a hearing). The provider should then file a WC-104B to be added as an intervening party to the carrier/worker dispute.

  Note: Whether or not an injured worker disputes the carrier's denial of a case by submitting a WC-104A form to the WCA, the worker's health insurance is responsible for the health services.

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 WC-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**.** R418.10117(3)
- Notifies the provider of their decision to pay, adjust or reject a medical provider's bill on form WC-739, entitled "Carrier's Explanation of Benefits." (EOB)
  - 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 HCS.
  - A copy must be sent to the injured worker and the provider.
  - A copy of the EOB form is located on the WCA's website.
  - All WCA case files continue to be identified by the social security number (SSN). Due to privacy laws it is important that the worker's 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.

Certification of a Carrier's Professional Review Program

Michigan's 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, as outlined in R 418.10101.

Applying for certification – This process is now done online at www.michigan.gov/wca.
(Updated October 2015)

- The carrier files online and must submit an **"***Application for Certification of Professional Review" (WC-590),* 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 online application need be submitted. The carrier may contact the WCA to see if the methodology on file is current.
- The online application can be submitted 90 days prior to the expiration date of the certification (R 418.101208(1)). The certification can be submitted electronically by the carrier or through a third party vendor to the WCA.
- The carrier must update their online information 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 an electronic "*Certification Of A Carrier's Professional Review Program"* to the carrier, service company and review company contacts listed on the application, 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 (HCS) for three years. Changes to this methodology must be in writing and forwarded to the HCS division within 30 calendar days of event.

A copy of the Carrier's Explanation of Benefits (WC-739) must be included with submission of the methodology. According to R 418.101001, the carrier must use a format approved by HCS. This format is available on the WCA website. The carrier must have approval from the HCS 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)

The carrier is responsible for manual or computer software edits for payments based upon the HCS rules and determining the accuracy of coding and edits performed. The Carrier's Explanation of Benefits (WC-739) shall detail reasons for recoding any procedure in accord with Part 13 of the HCS Rules.

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

Professional review is required by R418.101205 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.

Reconsiderations/Appeals (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).
- If the provider disagrees with the utilization decision or the payment is not made in accord with the HCS 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 (WC-104B) with the WCA on the current version of the form, sending a copy to the carrier.

Annual Medical Payment Report_R418.101401

A carrier is also required to submit online, an "Annual Medical Payment Report" (formerly WC-406) to Health Care Services, documenting the number of medical only cases, the number of wage loss cases and the corresponding total dollars spent on health care for those cases. The reporting period will begin each year on January 1 and end each year on December 31. The Annual Medical Payment Report is to be submitted electronically by February 28 for the preceding calendar year and should include:

- Carrier Information.
- Name, address, telephone number, and Email address of the person responsible for completion of the application.
- 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 wage loss was paid.

  Note: Refer to the definition of a case in the HCS Rules (R418.10108). 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 total payments for:
  - Indemnity (wage loss)
  - Mileage reimbursements
  - Vocational rehabilitation
  - Rehabilitation case management
  - Independent medical evaluation(s)

Service Companies and Insurance Companies will report as follows:

- *Service Companies*
  - Submit one consolidated report for all self-insured clients.
  - Report any payments for "tail/run-off" claims and all current business.
  - A separate list must be included listing all of the current self-insured employers/group funds and "tail/run-off" claims represented in the report.

    Note: When a service company administers claims for an insurance company, the data must be forwarded to the insurance company and the insurance company will submit the Annual Medical Payment Report. The insurance company will be responsible for compiling the data and submitting one consolidated report.

- *Self-Administered Employers or Self-Administered Group Funds*
    - Do not have a service company and are responsible for submitting their own reports.
- *Insurance Companies*
    - May submit one consolidated report for all insurance companies within their group. When more than one company is included in the report, a listing of all the companies included and their NAIC numbers must be attached.

Any service company business performed by an insurance company must be reported on a separate consolidated report. The insurance company will report their "service company business" in the same manner described above for service companies.

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.
- 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/ASC must include an invoice with implants that have current (non-expired) Medicare pass through status and are allowed separate payment under the CMS OPPS.

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 and test results.
- 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 HCS rules (See R 418.10113, 418.10114, 418.10901). The HCS Rules 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. R 418.10118, copying charge for medical records, 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 HCS 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 HCS Rules, are requested. Only those records for a specific date of injury are covered under the HCS 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 R 418.10113 and all other reports required by the HCS 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. This rule does not pertain to medical records requested by a subpoena that are part of litigation.

> **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 manual. Each section contains billing information specific to the category of services listed in that section.

Billing Information_R418.10901

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 (HCS) Rules for services to treat a covered work injury or illness.

The following claim forms are adopted by the HCS Rules for billing medical services:

- CMS-1500 (version 02/12) claim form for practitioner billing.
- UB-04 claim form to bill for facility and home health services.
- An NCPDP Workers Compensation/Property & Casualty Claim Form or an invoice for billing outpatient pharmacy services.
- American Dental Association 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 CPT procedure code 99199.

Balance Billing

According to R 418.10105, 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 when**:**

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

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

Procedure Codes

Procedure codes from *Current Procedural Terminology (CPT®) Professional Edition* and *HCPCS Level II Professional Edition* as adopted by reference in the HCS Rules, R 418.10107, are used to report medical services. CPT codes are used primarily for services, and HCPCS codes are used to report supplies and durable medical equipment (DME) as well as ancillary services such as dental services, hearing and vision services. The CPT procedure codes and MAP amounts are listed on the WCA website at http://www.michigan.gov/wca

Procedure codes and billing instructions are adopted from the CPT codebook, as referenced in R 418.10107. 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: R418.10902; R418.10902a; R418.10912

When an injectable drug is administered along with an evaluation and management service, the drug is billed and identified with CPT code 99070 or the appropriate J Code from HCPCS, and the National Drug Code (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) minus 10% with no dispensing fee.

When a vaccine or toxoid is administered along with a significantly separate Evaluation and Management (E & M) service, the appropriate E & M code should be reported in addition to the vaccine or toxoid administration code, in accordance with CPT guidelines. The vaccine or toxoid is billed with the applicable CPT code and the provider shall list the NDC number for the vaccine or toxoid on the CMS 1500. The vaccine or toxoid is reimbursed at AWP minus 10% with no dispensing fee.

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.

Reimbursement for repackaged pharmaceuticals shall be a maximum of AWP minus 10% based on 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. All pharmaceutical bills submitted for repackaged products shall include the original manufacturer or original distributor stock package NDC number. When there is not an

original manufacturer's NDC number 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.

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 CPT code 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. R418.10912(1). Until the carrier gives such direction, those providers are not bound by the HCS Rules.

- An outpatient or mail order pharmacy must submit charges for prescription medications on either an NCPDP Workers' compensation/Property & Casualty Universal 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 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. Brand or chemical name of the drug dispensed.
    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 SSN.

9. NDC number as listed in Red Book or Medi-Span.

Fees for biologicals, supplies and durable medical equipment are based upon the Medicare fees plus 5% (R 418.10913 and R 418.101003b). Biologicals that have NDC numbers shall be billed and reimbursed under R 418.10912, billing for prescription medications.

Fees for the L-code procedures are found using the worksheet and data source described in pages 3-4 of this manual. When a valid L-code does not list a set fee, the procedure is considered by report (BR).

Medical Marihuana

PA 481, 2012, 12/27/2012, (MCL 418.315a) Provides that: Notwithstanding the requirements of MCL 418.315, an employer is not required to reimburse or cause to be reimbursed charges for medical marihuana treatment.

Modifiers R418.10904(6)

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 WCA Employer Records division at (517) 284-8922 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 WCA website at www.michigan.gov/wca by clicking on Insurance Coverage Lookup in the Quicklinks on the right side of the screen. 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 contact the WCA Compliance & Employer Records division at (517) 284-8922 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 the Workers' Disability Compensation Act, MCL 418.315. 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 Health Care Services (HCS) 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 providers 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 or facility requests reconsideration of payment, the carrier may attempt to negotiate the fee. However, if the provider or facility refuses to negotiate fees, the carrier must reimburse the provider or facility according to the laws of the state where they are located and services were performed (R 418.101016(2)). The worker is not responsible for any unpaid balances of the provider's or facility'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 HCS 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. (R 418.101016(2))

Claims Review and Reduction

A carrier must ensure that their technical review programs (data software) result in correct payments in accord with the MAP amounts 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 that 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 with the WCA 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 codebook for correct coding and guidelines found in the HCS 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." R418.10109(q)

A provider may request reconsideration when the BR service is not reasonably reimbursed. R418.101301

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

Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier -59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries). (CPT® 2014, Professional Edition, pg.392).

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)

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 HCS 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 (WC-104B's)

Medical providers, insurance companies, and self-insured employers may request a mediation hearing with the WCA by submitting the "Application for Mediation or Hearing" form (WC-104B). A carrier may request a hearing to recover overpayments (refer to R 418.10120); 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 WC-104B to request a hearing or contest his case. The injured worker with questions should be instructed to call WCA customer service at (888) 396-5041

selecting #1 on each menu, or (517) 284-8900.

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 WC-104B whenever he learns that the worker's case is contested (the carrier denied compensability and the worker filed a WC-104A form).

  Note: When an injured worker does not dispute the carrier's denial of a case by submitting a WC-104A to the WCA, 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 WC-104B form to the WCA and sends a copy to the carrier or provider as appropriate. The WC-104B form is available on the WCA website, www.michigan.gov/wca. After completing the WC-104B, you must print both sides of the form according to WCA format. Documentation should not be sent with the application.

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://www.cms.gov/Medicare/Medicare.html?redirect=/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. As of April 1, 2014, providers were required by the Centers for Medicare and Medicaid Services (CMS) to use the 02/12 version of the CMS-1500 form. Therefore, this chapter will include instructions for the CMS-1500 (02/12) 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.

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 (02/12) claim form. Some of the requirements have changed with the 02/12 version. Bills must contain the information outlined below as of the latest revision of this manual.

The Workers' Compensation Carrier name and address should appear in the upper right hand corner.

CMS-1500 (02/12) Claim Form Elements 1 through 33

1. Mark other.
1a. Patient's Social Security Number (SSN).
2. Name of the patient.
3. Patient's sex and date of birth.
4. Name of the employer.

5. Patient's complete address omitting the telephone number.
6. Omit.
7. Employer address. Omit the telephone number.
8. Omit.
9. Omit.

9a. Omit.
9b. Omit.
9c. Omit.
9d. Omit.

10a-c. Mark the appropriate boxes.
10d. Condition codes if applicable.
11. Omit.
11a. Omit.
11b. Carrier claim number (after assigned)
11c. Omit.
11d. Omit.
12. Patient or Authorized person's signature
13. Insured or Authorized person's signature
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 or other source.
17a. Other ID number
17b. Enter NPI number of referring, ordering, or supervising provider
18. Date if applicable.
19. Additional claim information, if applicable. When reporting supplemental claim information, use the qualifier PWK for data, followed by the appropriate Report Type Code, the appropriate Transmission Type code, then the Attachment Control Number
20. Mark appropriate box
21. Diagnostic numeric or alpha code. Enter the applicable ICD indicator to identify which version of ICD codes is being reported
22. Resubmission and/or Original Reference Number if applicable
23. Omit
24. Each of the six lines is split length-wise and is shaded on the top portion for reporting supplemental information. The upper shaded portion shall be used to report the NDC if required. When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. If reporting both the repackaged NDC and the original NDC of a drug, used the shaded area to report the information in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code

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 alpha code(s) A-L as appropriate.
24f. Charge for each procedure billed.
24g. Complete this column for multiple units or total minutes for anesthesia services.
24h. Omit.
24i. Omit.
24j. Rendering Provider ID#, enter the NPI number in unshaded area of the field
25. Enter the billing provider's FEIN.
26. Enter the patient's account or case number.
27. Omit.
28. Enter the total charges.
29. Omit.
30. Omit.
31. Signature of Physician, including degrees or credentials
32. Complete if applicable.
32a. NPI of service facility if appropriate.
32b. Reporting of other ID numbers.
33. Billing provider's name, address, zip code, and telephone number.
33a. Billing provider's NPI number.
33b. Other ID #.

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

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 - Psychiatric Facility-partial hospitalization.
53 - Community mental health
56 - Psychiatric residential treatment center.
81 - Independent laboratory
99 - Other locations (other place of service)

American Dental Association Claim Form

1. Mark type of transaction.
2. Omit
3. Enter the name and address of the workers compensation carrier.
4. Omit
5. Omit
6. Omit
7. Omit
8. Enter the patient's SSN.
9. Omit
10. Omit
11. Omit.
12 Employer name and address
13. Omit
14 Omit.
15. Claim number if known.
16. Omit.
17. Enter the employer's name.
18. Omit.
19. Omit.
20. Enter the patient's name and address.
21. Enter the patient's date of birth.
22. Enter the patient's gender.
23. Enter the patient ID or account number.

24-32. Enter the procedure date, area of oral cavity, tooth system, tooth number or letter, tooth surface, procedure code, diagnosis code pointer, quantity, description, and fee.

33. Indicate with an "x" any missing teeth.
34. Enter the diagnosis code list qualifier.

34a. Enter the diagnosis code(s).

35. Add remarks for unusual services. Include any dental disorders that existed before the date of injury.
36. Patient Consent signature.
37. Authorize direct payment signature.
38. Enter place of treatment code.
39. Enter number of enclosures if applicable.
40. Mark yes or no. If no, skip to item #43.

41-42. Complete if applicable.

43-44. Complete if applicable.

45. Mark appropriate box.
46. Enter date of injury.
47. Omit.
48. Enter name and address of billing dentist or dental entity.
49. Enter NPI of billing dentist.

50. Enter license number if billing dentist is an individual.
51. Enter tax ID of billing dentist or dental entity.
52. Enter phone number of billing entity.
52a. Omit.
53. Enter treating dentist signature.
54. Enter treating dentist NPI number.
55. Enter license number of treating dentist.
56. Enter address of physical location where treatment was rendered.
56a. Enter provider specialty code.
57. Enter phone number of treating dentist.
58. Omit.

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 at www.nubc.org, or by calling NUBC at (800) 242-2626.
Hospitals must submit charges for practitioner services on the current CMS-1500 claim form. Examples of practitioner services billed by the hospital are:

- Anesthesiologists, certified anesthesiologist assistants, or nurse practitioners.
- Radiologists.
- Hospital-owned physician practices.
- Hospital-owned occupational or industrial clinic.

Chapter 6

Evaluation and Management: R418.10202

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 E/M 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 two categories: office visits, and hospital visits. For complete instructions on identifying and billing E/M services, refer to the Evaluation and Management Services Guidelines of the CPT codebook**.**

E/M service descriptors have seven 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.

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

Reimbursement for Nurse Practitioners & Physician Assistants

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 Maximum Allowable Payment (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

Consultations

Consultation CPT codes 99241-99245 and 99251-99255 are no longer payable. Providers should use the CPT code that most accurately reflects the service rendered.

Office Visit with a Surgical Procedure

The Surgery Guidelines in the CPT codebook 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 (e.g., 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 CPT 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 number. The drug is reimbursed at the average wholesale price of the drug (AWP) minus 10%. 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 codebook instructions for when the administration can be billed separately. The immunization vaccines are reimbursed at the AWP 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 CPT code 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 E/M 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 CPT 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 (outside normal hours) office service (R 418.10202)	$12.00
99199		Carrier arranged missed appointment (R 418.10112)	BR
99199	-32	Carrier or requested report, per page (R 418.10114)	$25.00
MPS01		Access Prescription Drug Monitoring Program (R 418.101008a)	$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
WC700	-C	Custom non-sterile compound dispense fee (R 418.101009)	$12.50
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.

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

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 418.101003b.

Chapter 7

Anesthesia: R418.10915 ***(Updated October 2015)***

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 CPT 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 codebook. 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) or a certified anesthesiologist assistant (AA). 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).

Anesthesia time begins when the anesthesiologist (or CRNA or AA) begins to prepare the patient for the induction of anesthesia in the operating room, or in an equivalent area, and ends when the anesthesiologist (or CRNA or AA) 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 CRNA, or a combination of a CRNA or an AA, and a physician providing medical direction or supervision. 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 CPT 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 or AA. 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 or AA services under the supervision of the anesthesiologist. The CRNA or AA 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 or AA, 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 or AA service.

<u>Physical Risk Modifiers and Emergency Anesthesia</u>

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

CPT 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, R418.10108(q) for a definition of emergency condition.
- On-call coverage does not meet criteria for billing CPT code 99140.

Chapter 8

Surgery: R418.10401

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

General

The schedule of maximum allowable payment (MAP) amounts for surgery is available on the website in the worksheet under the RBRVS tab and 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 that determines if an assist is permissible). See Surgical Assistant section below.
- Multiple procedure discount (with key indicating if applicable).
- Co surgeon and Team surgeon (with key that determines if permissible).

A claim for a surgical procedure (CPT 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. 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 noted in the RBRVS worksheet on the WCA website).

  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 CPT code 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 or general anesthesia provided by the surgeon is reported by adding modifier 47 to the basic service. (Note: Modifier 47 would not be used as a modifier for anesthesia services). The applicable anesthesia code would be placed on a separate line of the CMS-1500 claim form to describe the regional or general 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 “CPT® 2014 Professional Edition” for codes that are exempt from the application of modifier 51.

Exceptions:

- When the CPT codebook 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.

Surgical Assistant (Technical Assistant)

A technical surgical assistant fee may only be billed for designated surgical procedures as indicated in the RBRVS worksheet on the WCA website. In the Asst Surg box, found on the RBRVS worksheet, 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 code 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 code 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 code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s), including add-on procedure(s), are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.

> **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 code with the addition of modifier 66.

Wound Repair and Suture Removal

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 2014 CPT codebook (page 75).

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

- Simple Repair: When a wound is superficial, involves primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires a simple one layer closure. (When closure is done with adhesive strips, the surgical procedure is not charged and *only* the appropriate office visit is paid).
- Intermediate Repair: In addition to the above, when a wound requires layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal 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 are repaired, add together the lengths of those in the same classification (see above) and from all anatomic sites that are grouped together into the same CPT code descriptor. When multiple wounds of more than one classification are repaired, list the more complicated as the primary procedure, and the less complicated as the secondary procedure using modifier 59.

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 repair, in which case modifier 59 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 involving removal of dead tissue or foreign material may be billed separately using CPT codes 11000-11047. For the application of skin grafts or skin substitutes, see CPT codes 15100-15777.

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.

The payment for a cast/strapping CPT code includes the application and the removal of the cast, splint, or strapping. Casting supplies may be billed in addition to the procedure using CPT code 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 29000-29584). 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 codebook and bill as a surgical procedure.

Microsurgical Procedures

The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. CPT 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 CPT 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 codebook for complete listing of codes where the operating microscope is considered an inclusive component of the primary procedure.

Chapter 9

Radiology: R418.10504

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 CPT code and modifier 26. R418.10901(3)(f)

Payment Reductions for Multiple Procedures

Nuclear Medicine Procedures R418.10505

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 Procedure Payment Reduction (MPPR)

A multiple procedure payment reduction (MPPR) shall apply to specified radiology

procedures when performed in a freestanding radiology office, a non-hospital facility, or a physician's office or clinic. A complete list of codes subject to the MPPR is listed in the table below. The MPPR on these diagnostic imaging services applies to Professional Component (PC) and Technical Component (TC) services. It applies to both PC-only services, TC-only services, and to the PC and TC of global services.

The MPPR shall apply when more than one 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 the 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. The professional component shall be reduced to 75% of the maximum allowable payment, or the provider's charge, whichever is less.

A new diagnostic family indicator of **'88'** will denote those services subject to the diagnostic imaging reduction in the CMS Physician Fee Schedule.

> **Example:** If an MRI is performed in the same session, on the cervical spine and on the lumbar spine, the procedure with the highest relative value is paid in full and the technical component for the secondary procedure would be paid at 50% of the MAP, and the professional component for the secondary procedure would be paid at 75% of the MAP.

The complete list of codes subject to the MPPR on diagnostic imaging is in the chart below:

CY 2012 Diagnostic Imaging Service Subject to the Multiple Procedure Payment Reduction for PC & TC Services	
70336	mri, temporomandibular joint(s)
70450	Ct head/brain w/o dye
70460	Ct head/brain w/ dye
70470	Ct head/brain w/o & w/ dye
70480	Ct orbit/ear/fossa w/o dye
70481	Ct orbit/ear/fossa w/ dye
70482	Ct orbit/ear/fossa w/o & w/ dye
70486	Ct maxillofacial w/o dye
70487	Ct maxillofacial w/ dye
70488	Ct maxillofacial w/o & w/ dye
70490	Ct soft tissue neck w/o dye
70491	Ct soft tissue neck w/ dye
70492	Ct soft tissue neck w/o & w/ dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/ dye
70543	Mri orbit/face/neck w/o & w/dye

70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiography head w/o & w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiography neck w/o & w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
70554	Fmri brain by tech
71250	Ct thorax w/o dye
71260	Ct thorax w/ dye
71270	Ct thorax w/o & w/ dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/ dye
71552	Mri chest w/o & w/ dye
71555	Mri angio chest w/ or w/o dye
72125	CT neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72141	Mri neck spine w/o dye
72142	Mri neck spine w/dye
72146	Mri chest spine w/o dye
72147	Mri chest spine w/dye
72148	Mri lumbar spine w/o dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye
72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72159	Mr Angio spine w/o & w/dye
72191	Ct angiography, pelv w/o & w/ dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/ dye
72194	Ct pelvis w/o & w/ dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/ dye
72197	Mri pelvis w/o &w/ dye
72198	Mri angio pelvis w/ or w/o dye
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct upper extremity w/o & w/dye
73206	Ct angio upper extr w/o & w/dye
73218	Mri upper extr w/o dye

73219	Mri upper extr w/dye
73220	Mri upper extremity w/o & w/dye
73221	Mri joint upper extr w/o dye
73222	Mri joint upper extr w/dye
73223	Mri joint upper extr w/o & w/dye
73225	Mr Angio upr extr w/o & w/dye
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lower extremity w/o & w/dye
73706	Ct angio lower ext w/o & w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye
73720	Mri lower ext w/ & w/o dye
73721	Mri joint of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint of lwr extr w/o & w/dye
73725	Mr angio lower ext w or w/o dye
74150	Ct abdomen w/o dye
74160	Ct abdomen w/ dye
74170	Ct abdomen w/o & w/ dye
74174	Ct angio abd & pelv w/o & w/dye
74175	Ct angiography, abdom w/o & w/ dye
74176	Ct abd & pelvis
74177	Ct abd & pelvis w/contrast
74178	Ct abd & pelvis 1/>regns
74181	Mri abdomen w/o dye
74182	Mri abdomen w/ dye
74183	Mri abdomen w/o and w/ dye
74185	Mri angio, abdom w/ or w/o dye
74261	Ct colonography w/o dye
74262	Ct colonography w/ dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
75561	Cardiac mri for morph w/dye
75563	Cardiac mri w/stress img & dye
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt w/3d image, congen
75574	Ct angio hrt w/3d image
75635	Ct angio abdominal arteries
76604	Us exam, chest, b-scan
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum

77058	Mri, one breast
77059	Mri, broth breasts

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 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) R418.10202(10)

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 CPT code 76140 is billed, the written report must accompany the charges.

> **Note:** Billing CPT 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, reviews an x-ray that was 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 Item number 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 as per R418.10923(2).
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 CPT code, as noted in R418.101004(7).

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 80047-89398. 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 worksheet and data sources as described in pages 3-4 of this manual 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 in the CPT codebook 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 codes 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: R418.10201

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 (CPT codes 92550-92597) 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: R418.10207

Payment for a psychiatric diagnostic evaluation (CPT code 90791) 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. Payment for a psychiatric diagnostic evaluation with medical services (CPT code 90792) includes medical assessment, history and mental status, other physical exam elements as indicated, development of a treatment plan, when necessary, and the preparing of a written report that must be submitted with the required billing form. A new patient Evaluation & Management (E/M) code can be used in lieu of 90792 to describe a psychiatric diagnostic evaluation when appropriate.

CPT codes 90791 and 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapy services. Psychotherapy services may not be reported on the same day as 90791 and 90792. An E/M code may not be reported on the same day as 90791 and 90792 when performed by the same individual for the same patient.

Only a psychiatrist (MD or DO) may bill for those codes that include medical evaluation. Psychiatrists are not required to use a modifier.

Psychotherapy (CPT codes 90832-90838) must be billed under the CPT code most closely approximating the length of the session (ie, 16-37 minutes for CPT codes 90832 and 90833, 38-52 minutes for CPT code 90834 and 90836, and 53 or more minutes for CPT codes 90837 and 90838). Do not report psychotherapy of less than 16 minutes duration.

To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy when performed with evaluation and management services (90833, 90836, 90838) as add on codes to the E/M service.

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
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. No adjustment is necessary for diagnostic testing procedures performed.

Examples:

- When a fully licensed psychologist bills procedure code 90834, modifier -AH is required and the carrier payment is 100% of the MAP amount.
- If a limited license psychologist bills procedure code 90834, 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 90834, 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

Diagnostic studies (Nerve Conduction Tests, Electromyograms, Electroencephalograms, etc.) may be paid in addition to the office visit. 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 an office visit 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 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: R418.10208

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 all vision services. (R 418.10208(1) Intermediate and comprehensive vision 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. Payment shall be made for the following vision HCPCS codes: $50.00 for V2744, V2750, and V2760; $25.00 for V2715 ; and $160.00 for V2020.

Injectable Pharmaceuticals: R418.10902

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 CPT procedure code 99070 or the appropriate J-Code listed in the 2014 HCPCS Level II

book. The NDC number shall be listed on the bill and the drug is reimbursed at AWP minus 10% as determined by Red Book or Medi-Span.

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 minus 10% as determined by Red Book or Medi-Span.

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.

Custom compound topical medications (R418.101009)

Custom compound topical medications shall only be reimbursed when the following conditions are met:

- There is no readily available commercially manufactured equivalent
- No other FDA approved alternative drug is appropriate
- The active ingredients of each compound have an NDC number and are components of FDA approved drugs
- The drug has not been removed from the market for safety reasons
- The prescriber is able to demonstrate that the compound is clinically appropriate for the intended use

Reimbursement for custom compound topical medications will require the specific amount of each component drug used in the compound and its original manufacturer's NDC number. Reimbursement will be based on a maximum of the AWP minus 10% based upon the original manufacturer's NDC number, as provided by Redbook or Medi-Span, and pro-rated for each component amount used. Components without NDC numbers will not be reimbursed. A dispensing fee of $12.50 shall be billed with WC 700-C for a non-sterile compound. The provider shall dispense a 30 day supply per prescription. Reimbursement for a custom compound topical medication is limited to $600.00. Charges exceeding this amount will require review by the carrier.

Opioid treatment for chronic, non-cancer pain (R418.101008, R418.101008a)

In order to receive reimbursement for opioid treatment beyond 90 days following the onset of pain, the physician seeking reimbursement shall submit a written report to the payer. The written report must be submitted no later than 90 days after the initial opioid prescription fill for chronic pain and every 90 days thereafter. The written report must include the following:

- Relevant medical history, including any consultations obtained or review of data from an automated prescription drug monitoring program in the treating jurisdiction, such as the Michigan Automated Prescription System (MAPS).
- Summary of conservative care provided which focused on increased function and return to work, including a statement on why prior conservative measures

were ineffective or contraindicated.

- A statement that the attending physician has considered results from an appropriate industry accepted screening tool to detect an increased risk of abuse or adverse outcomes.
- A treatment plan, which must include overall treatment goals and functional progress, periodic urine drug screens, an effort to reduce pain through the use of non-opioid medications and/or alternative non-pharmaceutical strategies, consideration of weaning from opioid use, and an opioid treatment agreement. The opioid treatment agreement shall be signed by the attending physician and the worker and shall be reviewed, updated, and renewed every 6 months.

Reimbursement for prescribing and dispensing opioid medications may be denied only after a reasonable period of time is provided for the weaning of the injured worker from the opioid medications, and alternative means of pain management have been offered.

Providers may bill for the additional services required for compliance with R 418.101008a utilizing CPT code 99215 for the initial 90 day report and all subsequent follow-up reports at 90 day intervals. In addition, providers may bill $25 utilizing a specific Michigan workers' comp code, MPS01, for accessing the automated prescription drug monitoring program every 6 months. Fees for laboratory procedures are set in accordance with R 418.101503.

<u>Modifiers</u>

The following modifiers are used in medical services. Consult the current CPT codebook 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: R418.10203(2)

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, and others that may be permitted by the expanded scope of practice as described in MCL 418.315(1), may be reimbursed but reimbursement is not required by a carrier.

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

Physical Medicine Services: R418.10212

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, CPT codes 97001-97799, are provided by a physical therapist and occupational therapy is when CPT codes 97001-97799 are provided by an 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 updated progress report every 30 days. Requests for additional notes may be charged for in accord with R 418.10118.

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. 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 CPT codes (98940-98942). R418.10203(3)(a)
- Evaluation of on-going osteopathic manipulation services is included with the OMT series of CPT codes (98925-98929). R418.10203(3)(b)

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, CPT codes 98925-98942, are considered therapeutic procedures in addition to CPT codes 97110-97546). R418.10203(7)(b)

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 CPT code 97035-22 and is reimbursed the same as CPT code 97035 plus $2.00 for the active ingredient. R418.10212(7)(d)

Fluidotherapy**,** a dry whirlpool treatment, shall be reported using code 97022. R418.10212(7)(h)

Hot/Cold pack application, CPT code 97010, is a bundled procedure code and shall not be reimbursed separately. R 418.10212 (9)(b)

<u>Documentation and Policies</u>

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): R418.10212(6)

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: R418.10212(8)

Work hardening and work conditioning are goal-oriented therapies designed to prepare injured workers for their return to work. Procedure codes 97545 and 97546 are used 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: R418.10212(4)

A carrier may request a physician, a licensed 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 Description	MAP
WC500	Job site evaluation: patient specific, initial 60 minutes	BR
WC505	Each additional 30 minutes	BR
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 WCA's website at 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 CPT code 99070. If there is no MAP listed for the procedure code and if the charge exceeds $35.00, then 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 418.101003(b).

- 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 provider's 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 HCPCS code 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.

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 code or CPT code 99070. Reimbursement is made according to R 418.101003(b) 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 HCPCS codes.

Billing Guidelines: R418.10212

When billing physical therapy or occupational therapy, a physician's prescription should be attached to the charges. Pursuant to MCL 418.315, an employer is not required to reimburse for a physical therapy service, provided by a Physical Therapist or a Physical Therapy Assistant under the supervision of a licensed PT, without a

prescription.

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. 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.

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: R418.10121

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 nurse 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 CPT code 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. R418.10404(2)(a)

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 a 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 a 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 the 2014 HCPCS Level II codebook for a complete listing of all ancillary procedures including descriptors.

Expendable Medical and Surgical Supplies (A4000-A8999)

Durable Medical Equipment (E0100-E9999): R418.11003b

A worksheet and data source described in pages 3-4 of this manual have been established for the payment of durable medical equipment (DME) and expendable medical supplies. The worksheet provides that these services shall be reimbursed at Medicare plus 5%.

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. Invoice cost should not include tax and/or shipping and handling charges. 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): R418.101003

The Maximum Allowable Payments (MAP) for L-Code procedures are listed in R 418.10214. L-Code procedures not listed in this rule 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 means 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 is constructed by a prosthetist, a practitioner who is skilled in the design, fabrication, and fitting of artificial limbs or prosthesis.

Other Ancillary Services: R418.10106

The following ancillary services are by report (BR) and are reimbursed at either the practitioner's usual and customary charge or reasonable, whichever is less, as defined by the HCS Rules. A complete listing of all of the procedure codes and their descriptors may be found in the 2014 HCPCS Level II codebook:

- 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 HCS 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. R418.10109(q)
>
> "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. R418.10109(y)

Hearing aid suppliers shall use the appropriate HCPCS code(s), V5008- V5299, listed in the HCPCS Level II book as referenced in 418.10107(2) to describe services provided. When requesting payment for hearing aids a minimum of 2 comparable written quotations shall be required for hearing aids which exceed $1,500.00 per hearing aid, including related services such as orientation, fitting, ear molds, support, adjustment, conformity check, batteries, warranties and follow-up. Only a single price quotation shall be required for hearing aids, including related services, that cost $1,500.00 or less per hearing aid.

Dental services are billed on the standard American Dental Association 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 care 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 care 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: R418.10106

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 (HCS) 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 HCS Rules, R418.10108 (t), shall submit facility charges on a UB-04 claim form to the carrier. The exception to this is the ASC (Ambulatory Surgical Center)/FSOF (freestanding surgical outpatient facilities) 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 online at http://www.nubc.org/become.html, or by mail at AHA Services, PO Box 933283, Atlanta, GA 31193-3283, phone 800-242-2626.

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

- Revenue codes.
- ICD.9.CM codes or ICD 10 codes when ICD 10 codes are implemented by CMS.
- 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

procedure codes are also added to identify what physical medicine procedures are being billed on the UB. Refer to Part 10, R 418.101015 (Rule 1015), of the HCS Rules for rules regarding facility reimbursement.

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, certified anesthesiologist assistant, or anesthesiologist.
- 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.

<u>Ambulatory surgical center (ASC)/Free Standing Surgical Outpatient Facilities (FSOF):</u> R418.10923(b)

The ASC/FSOF 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 an ASC/FSOF.

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

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

ASC/FSOF 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. (Certain exceptions apply; contact the Michigan Bureau of Community and Health Systems for more information.)

> **Note:** Hospital owned ASC/FSOF 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 ASC/FSOF 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 ASC/FSOF is based upon the Medicare payment rate

for an ASC times 1.30.

[Medicare payment for ASC rate] X [1.30]

The MAP for the procedures performed in an ASC/FSOF are listed on the WCA website under the ASC tab of the current HCS rules. See worksheet and data source described in pages 3-4 of this manual.

The following billing and payment rules shall apply:

- ASC/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 ASC/FSOF. Supplies are included in the surgical procedure. The carrier shall pay the MAP 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 ASC/FSOF claim. The multiple surgery payment rule applies.
- The technical component (-TC) of certain radiology services, certain drugs and biologicals, if allowed separate payment under the Medicare Outpatient Prospective Payment System (OPPS), will be provided under the ASC/FSOF tab of the current fee schedule on the WCA website.
- Appropriate laboratory procedures may be billed and will be reimbursed at the MAP 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, if allowed separate payment under the Medicare OPPS. 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.
- Practitioner services shall not be included on the facility bill.
- Items implanted into the body that remain in the body at discharge from the facility may **not** be billed separate from the surgical procedure unless designated by CMS as a pass through item. **Please note the expiration dates on CMS pass through items. Only services with expired codes that were incurred prior to the expiration date are separately reimbursable.** The facility shall bill implant items with the appropriate HCPCS code that is reimbursable under the Outpatient Prospective Payment System (OPPS). A report listing a description of the implant and a copy of the facility's cost invoice, including any full or partial credit given for the implant, shall be included with the bill.

List of Device Category HCPCS Codes and Definitions Used for Present and Previous PassThrough Payment ***

	HCPCS Codes	Category Long Descriptor	Date First Populated	Pass-Through Expiration Date***
1	C1883*	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	8/1/00	12/31/02
2	C1765*	Adhesion barrier	10/01/00 – 3/31/01;	12/31/03
3	C1713*	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)	8/1/00	12/31/02
4	L8690	Auditory osseointegrated device, includes all internal and external components	1/1/07	12/31/08
5	C1715	Brachytherapy needle	8/1/00	12/31/02
6	C1716#	Brachytherapy source, non-stranded, Gold-198, per source	10/1/00	12/31/02
7	C1717#	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	1/1/01	12/31/02
8	C1718#	Brachytherapy source, Iodine 125, per source	8/1/00	12/31/02
9	C1719#	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	10/1/00	12/31/02
10	C1720#	Brachytherapy source, Palladium 103, per source	8/1/00	12/31/02
11	C2616#	Brachytherapy source, non-stranded, Yttrium-90, per source	1/1/01	12/31/02
12	C2632	Brachytherapy solution, iodine – 125, per mCi	1/1/03	12/31/04
13	C1721	Cardioverter-defibrillator, dual chamber (implantable)	8/1/00	12/31/02
14	C1882*	Cardioverter-defibrillator, other than single or dual chamber (implantable)	8/1/00	12/31/02
15	C1722	Cardioverter-defibrillator, single chamber (implantable)	8/1/00	12/31/02
16	C1888*	Catheter, ablation, non-cardiac, endovascular (implantable)	7/1/02	12/31/04
17	C1726*	Catheter, balloon dilatation, non-vascular	8/1/00	12/31/02
18	C1727*	Catheter, balloon tissue dissector, non-vascular (insertable)	8/1/00	12/31/02
19	C1728	Catheter, brachytherapy seed administration	1/1/01	12/31/02
20	C1729*	Catheter, drainage	10/1/00	12/31/02
21	C1730*	Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)	8/1/00	12/31/02
22	C1731*	Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)	8/1/00	12/31/02
23	C1732*	Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping	8/1/00	12/31/02
24	C1733*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip	8/1/00	12/31/02

25	C2630*	Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool-tip	10/1/00	12/31/02
26	C1886	Catheter, extravascular tissue ablation, any modality (insertable)	01/01/12	12/31/13
27	C1887*	Catheter, guiding (may include infusion/perfusion capability)	8/1/00	12/31/02
28	C1750	Catheter, hemodialysis/peritoneal, long-term	8/1/00	12/31/02
29	C1752	Catheter, hemodialysis/peritoneal, short-term	8/1/00	12/31/02
30	C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)	8/1/00	12/31/02
31	C1759	Catheter, intracardiac echocardiography	8/1/00	12/31/02
32	C1754	Catheter, intradiscal	10/1/00	12/31/02
33	C1755	Catheter, intraspinal	8/1/00	12/31/02
34	C1753	Catheter, intravascular ultrasound	8/1/00	12/31/02
35	C2628	Catheter, occlusion	10/1/00	12/31/02
36	C1756	Catheter, pacing, transesophageal	10/1/00	12/31/02
37	C2627	Catheter, suprapubic/cystoscopic	10/1/00	12/31/02
38	C1757	Catheter, thrombectomy/embolectomy	8/1/00	12/31/02
39	C1885*	Catheter, transluminal angioplasty, laser	10/1/00	12/31/02
40	C1725*	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	8/1/00	12/31/02
41	C1714	Catheter, transluminal atherectomy, directional	8/1/00	12/31/02
42	C1724	Catheter, transluminal atherectomy, rotational	8/1/00	12/31/02
43	C1758	Catheter, ureteral	10/1/00	12/31/02
44	C1760*	Closure device, vascular (implantable/insertable)	8/1/00	12/31/02
45	L8614	Cochlear implant system	8/1/00	12/31/02
46	C1762*	Connective tissue, human (includes fascia lata)	8/1/00	12/31/02
47	C1763*	Connective tissue, non-human (includes synthetic)	10/1/00	12/31/02
48	C1881	Dialysis access system (implantable)	8/1/00	12/31/02
49	C1884*	Embolization protective system	1/01/03	12/31/04
50	C1749	Endoscope, retrograde imaging/illumination colonoscope device (implantable)	10/01/10	12/31/12
51	C1764	Event recorder, cardiac (implantable)	8/1/00	12/31/02
52	C1767**	Generator, neurostimulator (implantable), non-rechargeable	8/1/00	12/31/02
53	C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	1/1/06	12/31/07

54	C1768	Graft, vascular	1/1/01	12/31/02
55	C1769	Guide wire	8/1/00	12/31/02
56	C1770	Imaging coil, magnetic resonance (insertable)	1/1/01	12/31/02
57	C1891	Infusion pump, non-programmable, permanent (implantable)	8/1/00	12/31/02
58	C2626*	Infusion pump, non-programmable, temporary (implantable)	1/1/01	12/31/02
59	C1772	Infusion pump, programmable (implantable)	10/1/00	12/31/02
60	C1818*	Integrated keratoprosthesis	7/1/03	12/31/05
61	C1821	Interspinous process distraction device (implantable)	1/1/07	12/31/08
62	C1893	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away	10/1/00	12/31/02
63	C1892*	Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away	1/1/01	12/31/02
64	C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away	1/1/01	12/31/02
65	C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	8/1/00	12/31/02
66	C2629	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, laser	1/1/01	12/31/02
67	C1776*	Joint device (implantable)	10/1/00	12/31/02
68	C1895	Lead, cardioverter-defibrillator, endocardial dual coil (implantable)	8/1/00	12/31/02
69	C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)	8/1/00	12/31/02
70	C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)	8/1/00	12/31/02
71	C1900*	Lead, left ventricular coronary venous system	7/1/02	12/31/04
72	C1778	Lead, neurostimulator (implantable)	8/1/00	12/31/02
73	C1897	Lead, neurostimulator test kit (implantable)	8/1/00	12/31/02
74	C1898	Lead, pacemaker, other than transvenous VDD single pass	8/1/00	12/31/02
75	C1779*	Lead, pacemaker, transvenous VDD single pass	8/1/00	12/31/02
76	C1899	Lead, pacemaker/cardioverter-defibrillator combination (implantable)	1/1/01	12/31/02
77	C1780*	Lens, intraocular (new technology)	8/1/00	12/31/02
78	C1840	Lens, intraocular (telescopic)	10/01/11	12/31/13
79	C1878*	Material for vocal cord medialization, synthetic (implantable)	10/1/00	12/31/02
80	C1781*	Mesh (implantable)	8/1/00	12/31/02
81	C1782*	Morcellator	8/1/00	12/31/02
82	C1784*	Ocular device, intraoperative, detached retina	1/1/01	12/31/02

83	C1783	Ocular implant, aqueous drainage assist device	7/1/02	12/31/04
84	C2619	Pacemaker, dual chamber, non rate-responsive (implantable)	8/1/00	12/31/02
85	C1785	Pacemaker, dual chamber, rate-responsive (implantable)	8/1/00	12/31/02
86	C2621*	Pacemaker, other than single or dual chamber (implantable)	1/1/01	12/31/02
87	C2620	Pacemaker, single chamber, non rate-responsive (implantable)	8/1/00	12/31/02
88	C1786	Pacemaker, single chamber, rate-responsive (implantable)	8/1/00	12/31/02
89	C1787*	Patient programmer, neurostimulator	8/1/00	12/31/02
90	C1788	Port, indwelling (implantable)	8/1/00	12/31/02
91	C1830	Powered bone marrow biopsy needle	10/01/11	12/31/13
92	C2618	Probe, cryoablation	4/1/01	12/31/03
93	C2614	Probe, percutaneous lumbar discectomy	1/1/03	12/31/04
94	C1789	Prosthesis, breast (implantable)	10/1/00	12/31/02
95	C1813	Prosthesis, penile, inflatable	8/1/00	12/31/02
96	C2622	Prosthesis, penile, non-inflatable	10/1/01	12/31/02
97	C1815	Prosthesis, urinary sphincter (implantable)	10/1/00	12/31/02
98	C1816	Receiver and/or transmitter, neurostimulator (implantable)	8/1/00	12/31/02
99	C1771*	Repair device, urinary, incontinence, with sling graft	10/1/00	12/31/02
100	C2631*	Repair device, urinary, incontinence, without sling graft	8/1/00	12/31/02
101	C1814*	Retinal tamponade device, silicone oil	4/1/03	12/31/05
102	C1773*	Retrieval device, insertable	1/1/01	12/31/02
103	C2615*	Sealant, pulmonary, liquid (Implantable)	1/1/01	12/31/02
104	C1817*	Septal defect implant system, intracardiac	8/1/00	12/31/02
105	C1874*	Stent, coated/covered, with delivery system	8/1/00	12/31/02
106	C1875*	Stent, coated/covered, without delivery system	8/1/00	12/31/02
107	C1876*	Stent, non-coated/non-covered, with delivery system	8/1/00	12/31/02
108	C1877	Stent, non-coated/non-covered, without delivery system	8/1/00	12/31/02
109	C2625*	Stent, non-coronary, temporary, with delivery system	10/1/00	12/31/02
110	C2617*	Stent, non-coronary, temporary, without delivery system	10/1/00	12/31/02
111	C1819	Tissue localization excision device	1/1/04	12/31/05

112	C1879*	Tissue marker (implantable)	8/1/00	12/31/02
113	C1880	Vena cava filter	1/1/01	12/31/02
114	C1841	Retinal prosthesis, includes all internal and external components	10/1/13	12/31/2015
115	C2624	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	1/1/2015	TBD

- Implants, if designated by CMS as current (non-expired) pass through items and allowed separate payment under the OPPS, 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%.

Other Facilities

A licensed facility, excepting a ASC/FSOF, 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 Community and Health Systems at (517) 241-1970.

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**,** AA 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: R418.101016

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 ***(Updated October 2015)***

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

Insurance Coverage look-up call (517) 284-8922 or go to the WCA website at http://www.michigan.gov/wca. Insurance coverage look up will be found under the quicklinks tab on the right side.

Injured workers call (888) 396-5041.

The Health Care Services Rules and Fee Schedule Programs may be downloaded, at no charge, from the Workers' Compensation Agency website: http://www.michigan.gov/wca. For assistance call (517) 284-8900.

Fee schedule, billing questions, how to obtain or how to complete the forms WC-104B, WC-590 and WC-406 call (517) 284-8898.

> **Note:** Hearings are generally scheduled within 6-8 weeks. Allow for this processing time to elapse before contacting the Workers' Compensation Agency. For questions regarding WC-104B telephonic hearings contact:
>
> Facilitator: Angie Lewis
> (517) 284-8893
> e-mail address: lewisa1@michigan.gov
>
> Facilitator: Kathy Witchell
> (517) 284-8892
> e-mail address: witchellk@michigan.gov
>
> Facilitator: Kristina Kloc
> (517) 284-8898
> e-mail address: klock@michigan.gov

Forms

- Provider's Request for Reconsideration (WC-750): This is not a required form for providers, however, its use is strongly encouraged.
- Provider's Report of Claim (WC-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 (HCS) Rules is mandatory before requesting a mediation hearing (Parts 9, 10 and 13 of the HCS rules). This form is available on the agency website, www.michigan.gov/wca.

  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, along with a copy of the Provider's Request for Reconsideration, if appropriate. A copy must go to the carrier.
- Carriers Explanation of Benefits (WC-739). A copy must be sent to the provider and injured worker.
- Annual Medical Payment Report (Formerly WC-406). This must be filed online and is available on the agency website.
- 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 (Formerly WC-590). This can be filed online or by mailing to the WCA and is available on the agency website.
- Notice of Certification of a Carrier's Professional Health Care Review Program (Formerly WC-591). This notification will be sent electronically by the agency.

  Note: Refer to the given agency contact information to verify the current version date.

Claim Forms

- The standard practitioner claim form is the most recent CMS-1500 form (02/12). 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 (800) 242-2626 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.
- NCPDP Workers Compensation/Property & Casualty Form. To obtain this form, contact NCPDP at www.ncpdp.org, select Products, then Universal Claim Forms or call 1-877-817-3676.

Source Documents

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

- Current Procedural Terminology (CPT®) Professional Edition
- HCPCS Level II Professional Edition
- Medicare RBRVS: The Physicians' Guide
- International Classification of Diseases
- Red Book Online service
- Medi-Span Drug Information Database
- Official UB-04 Data Specifications Manual

1-WC/P&C Indicator: 2-Date of Billing: mm dd ccyy

NCPDP

WORKERS COMPENSATION/ PROPERTY & CASUALTY CLAIM FORM
Version 1.1 - 05/2009

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FOR OFFICE USE ONLY
15 (Document Control Number)

PATIENT

3-Last: 4-First:
5-Address:
6-City: 7-State:
8-Zip: 9-Tel #:
10-D.O.B.: mm dd ccyy 11-D.O.I.: mm dd ccyy
12-I.D.: 13-Qualifier: 14-Gender:

CARRIER

16-Jurisdictional State:
17-Claim Ref #:
18-Name:
19-Address:
20-City: 21-State:
22-Zip:

SIGNATURE OF PROVIDER
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)

30-(Signed) 31-(Date)

ATTENTION PROVIDER! PLEASE READ ATTESTATION STATEMENT ON REVERSE SIDE

EMPLOYER

23-Name:
24-Address:
25-City: 26-State:
27-Zip: 28-Tel #.:
29-Contact Name:

PHARMACY

32-ID: 33-Qual:
34-Name:
35-Address:
36-City: 37-State:
38-Zip:
39-Tel #:

PRESCRIBER

40-ID: 41-Qual:
42-Last:
43-First:
44-Address:
45-City: 46-State:
47-Zip:
48-Tel #:

PAYEE

49-ID: 50-Qual:
51-Name:
52-Address:
53-City: 54-State:
55-Zip:
56-Tel #:

JURISDICTION

57-Jurisdiction #1:
58-Jurisdiction #2:
59-Jurisdiction #3:
60-Jurisdiction #4:
61-Jurisdiction #5:

CLAIM

62-Prescription/ Service Ref. #	63-Qual.	64-Fill #	65-Date Written mm dd ccyy	66-Date of Service mm dd ccyy	67-Submission Clarification	68-Prescription Origin

69-Product/Service ID	70-Qual.	71-Quantity Dispensed	72-Days Supply	73-DAW Code	74-Prior Auth #. Submitted	75-PA. Type

76-Description	77-Strength	78-Unit Of Measure	79-Other Coverage	80-Delay Reason

COB	81-Other Payer ID	82-Qual	83-Other Payer Date MM DD CCYY	84-Other Payer Rejects	DUR	DUR / PPS / CODES 85-Reason / 86-Service / 87-Result

88-Level of Effort	89-Procedure Modifier	90-Dosage Form Description Code	91-Dispensing Unit Form Indicator	92-Route of Administration	93-Ingredient Component Count

COMPOUND

	94-Product Name	95-Product ID	96-Qual	97-Ingredient Qty	98-Ingredient Drug Cost	99-Basis Cost
1						
2						
3						
4						
5						
6						
7						

Pricing (Format (1,234.56)

100-Usual & Customary Charge	101-Basis of Cost Det.	102-Ingredient Cost Submitted	103-Dispensing Fee Submitted	104-Other Amount Submitted	105-Sales Tax Submitted	106-Gross Amount Due (Submitted)

107-Patient Paid Amount	108-Other Payer Amount Paid	109-Other Payer Patient Resp. Amt.	110-Net Amount Due

SAMPLE

ADA American Dental Association® 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 (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

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. Reserved For Future Use

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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**")
A _____ C _____
B _____ D _____

31a. Other Fee(s)

32. 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 ☐ (e.g. 11=office; 22=O/P Hospital)
(Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

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

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

42. Months of Treatment

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

44. Date of 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

SAMPLE

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
or go online at adacatalog.org

ADA American Dental Association®

America's leading advocate for oral health

The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

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 #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.

B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.

C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.

D. All dates must include the four-digit year.

E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)

Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)

Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf"

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

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

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

SAMPLE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. 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. Rsvd for NUCC Use

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. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

SAMPLE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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 ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. Rsvd for NUCC Use

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.)

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

SIGNED DATE

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO | *If yes*, complete items 9, 9a and 9d.

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 ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) | ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 2 3 4 5 6

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. Rsvd for NUCC Use

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.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

SAMPLE