

WORKERS' COMPENSATION AGENCY

DEPARTMENT OF LABOR & ECONOMIC GROWTH

WORKER'S COMPENSATION HEALTH CARE SERVICES

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(By authority conferred on the worker's compensation agency by sections 205 and 315 of 1969 PA 317, section 33 of 1969 PA 306, Executive Reorganization Order No. 1982-2, Executive Reorganization Order No. 1986-3, and Executive Reorganization Order No. 1990-1, MCL 418.205, 418.315, 24.233, 18.24, 418.1, and 418.2)

R 418.10101, R 418.10103, R 418.10104, R 418.10107, R 418.10108, R 418.10109, R 418.10110, R 418.10111, R 418.10115, R 418.10117, R 418.10118, R 418.10120, R 418.10404, R 418.10701, R 418.10901, R 418.10902, R 418.10904, R 418.10907, R 418.10912, R 418.10915, R 418.10921, R 418.10923, R 418.10925, R 418.101001, R 418.101002, R 418.101003, R 418.101004, R 418.101015, R 418.101016, R 418.101017, R 418.101022, R 418.101101, R 418.101102, R 418.101103, R 418.101104, R 418.101105, R 418.101204, R 418.101205, R 418.101206, R 418.101207, R 418.101208, R 418.101209, R 418.101210, R 418.101301, R 418.101303, R 418.101304, R 418.101305, R 418.101401, R 418.101402, R 418.101404, R 418.101501, R 418.101502 and R 418.101503 are amended, R 418.10923B and R 418.101023 are added to the Administrative code.

PART 1. GENERAL PROVISIONS

R 418.10101 Scope.

Rule 101. (1) These rules do all of the following:

(a) Establish procedures by which the employer shall furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably possible, and relieve from the effects of the injury.

(b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.

(c) Establish procedures by which a health care provider shall be paid.

(d) Provide for the identification of utilization of health care and health services above the usual range of utilization for such services, based on medically accepted standards, and provide for acquiring by a carrier and by the workers' compensation agency the necessary records, medical bills, and other information concerning any health care or health service under review.

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(e) Establish a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.

(f) Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers, which have made excessive charges or which have required unjustified treatment, hospitalization, or visits.

(g) Provide for the review by the workers' compensation agency of the records and medical bills of any health facility or health care provider which have been determined by a carrier not to be in compliance with the schedule of charges established by these rules or to be requiring unjustified treatment, hospitalization, or office visits.

(h) Provide for the certification by the workers' compensation agency of the carrier's professional utilization review program.

(i) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health facility or health care provider may be required by the carrier to explain the necessity in writing.

(j) Provide for the interaction of the workers' compensation agency and the department of labor and economic growth for the utilization of departmental procedures for the resolution of workers' compensation disputes.

(k) Are intended for the implementation and enforcement of section 315(2) to (9) of the act, provide for the implementation of the workers' compensation agency's review and decision responsibility vested in it by those statutory provisions. The rules and definitions are not intended to supersede or modify the workers' disability compensation act, the administrative rules of practice of the workers' compensation agency, or court decisions interpreting the act or the workers' compensation agency's administrative rules.

(2) An independent medical examination shall be exempt from these rules and may be requested by a carrier or an employee. An independent medical examination, (IME), shall be conducted by a practitioner other than the treating practitioner. Reimbursement for the independent medical evaluation shall be based on a contractual agreement between the provider of the independent medical evaluation and the party requesting the examination.

(3) These rules and the fee schedule shall not pertain to health care services which are rendered by an employer to its employee in an employer-owned and employer-operated clinic.

(4) If a carrier and a provider have a contractual agreement designed to reduce the cost of workers' compensation health care services below what would be the aggregate amount if the fee schedule were applicable, the contractual agreement shall be exempt from the fee schedule. The carrier shall be required to do both of the following:

(a) Perform technical and professional review procedures.

(b) Provide the annual medical payment report to the health care services division of the workers' compensation agency.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct 24, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10102 Claim filing limitations.

Rule 102. (1) A provider shall bill a carrier within one year of the date of service for consideration of payment.

(2) The one year filing rule shall not apply if the provider bills after the one year requirement under subrule (1) of this rule due to litigation or subrogation.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10103 Complaints.

Rule 103. Any person who is affected by these rules may submit a written complaint to the workers' compensation agency regarding the actions of any other person who is affected by these rules.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10104 Reimbursement to injured worker or to health insurer for compensable medical services.

Rule 104. (1) Notwithstanding any other provision of these rules, if an injured worker has paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the injured worker shall be fully reimbursed by the carrier.

(2) The injured worker may submit the request for reimbursement on a medical or dental claim form, but shall supply to the carrier a copy of a statement including the provider name, the date of service, the procedure and diagnosis and documentation of the amount paid.

(3) When a health insurer pays for a medical service to treat an injured worker and subsequently requests reimbursement from the workers' compensation carrier, the health insurer is not required to submit the request on a CMS 1500, or a UB-92 claim form, or other medical or dental claim form. The health insurer shall supply to the workers' compensation carrier, or the carrier's designee, a claim detail showing the date of service, the amount billed and paid, the procedure code and diagnosis for the rendered services. The workers' compensation carrier shall reimburse the health insurer the provider's usual and customary fee or the maximum allowable fee, whichever is less, for the compensable medical services in accordance with these rules. If the health insurer reimbursed the provider less than the amount allowed by these rules, then the workers' compensation carrier shall reimburse the amount paid by the health insurer.

History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10105 Balance billing amounts in excess of fees.

Rule 105. The provider shall not bill the injured worker for any amount for health care services, or for late fees incurred, provided for the treatment of a covered injury or illness when the amount is disputed by the carrier pursuant to its utilization review program or when the amount exceeds the maximum allowable payment established by these rules.

History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003.

R 418.10106 Procedure codes; relative value units; other billing information.

Rule 106. (1) Upon annual promulgation of R 418.10107, the health care services division of the workers' compensation agency shall publish a manual separate from these rules containing all of the following information:

- (a) All CPT® procedure codes used for billing health care services.
- (b) Medicine, surgery, and radiology procedures and their associated relative value units.
- (c) Hospital maximum payment ratios.
- (d) Billing forms and instruction for completion.

(2) The procedure codes and standard billing and coding instructions for medicine, surgery, and radiology services shall be adopted from the most recent publication entitled "Physicians'

Current Procedural Terminology, (CPT[®])” as adopted by reference in R 418.10107. However, billing and coding guidelines published in “Physicians’ Current Terminology, (CPT[®])” do not guarantee reimbursement. A carrier shall only reimburse medical procedures for a work-related injury or illness that are reasonable and necessary and are consistent with accepted medical standards.

(3) The formula and methodology for determining the relative value units shall be adopted from the “Medicare RBRVS Fee Schedule” as adopted by reference in R 418.10107 using geographical information for Michigan. The geographical information, (GPCI), for these rules is a melded average using 60% of the figures published for Detroit added to 40% of the figures published for the rest of the state.

(4) The maximum allowable payment for medicine, surgery, and radiology services shall be determined by multiplying the relative value unit assigned to the procedure times the conversion factor listed in the reimbursement section, part 10 of these rules.

(5) Procedure codes from “Medicare’s National Level II Codes HCPCS” as adopted by reference in 418.10107 shall be used to describe all of the following services:

- (a) Ambulance services.
- (b) Medical and surgical expendable supplies.
- (c) Dental procedures.
- (d) Durable medical equipment.
- (e) Vision and hearing services.
- (f) Home health services.

(6) Both of the following medical services shall be considered “By Report” (BR):

(a) All ancillary services listed in “Medicare’s National Level II CODES HCPCS”, referenced in R 418.10106.

(b) All CPT[®] procedure codes that do not have an assigned relative value.

History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2004 MR 5 Eff. Feb. 20, 2004.

R 418.10107 Source documents; adoption by reference.

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

(a) "Physicians’ Current Procedural Terminology (CPT[®]) 2005," standard edition, copyright October 2004, published by the American Medical Association, PO Box 930876, Atlanta GA, 31193-0876, order # OP054105CFJ ISBN: 1-57947-578-7, 1-800-621-8335. The publication may be purchased at a cost of \$62.95, plus \$9.95 for shipping and handling as of the time of adoption of these rules. Permission to use this publication is on file in the workers' compensation agency.

(b) "Medicare's National Level II Codes, HCPCS, 2005," copyright November 2004, published by the American Medical Association, P.O. Box 930876 Atlanta GA 31193-0876, order # OP095105CFJ ISBN: 1-57947-571-X, customer service 1-800-621-8335. The publication may be purchased at a cost of \$89.95, plus \$11.95 for shipping and handling as of the time of adoption of these rules.

(c) “Medicare RBRVS 2004: The Physicians’ Guide,” published by the American Medical Association, 515 North State Street, Chicago IL, 60610, 1-800-621-8335. The publication may

be purchased at a cost of \$79.95, plus \$11.95 shipping and handling as of the time of adoption of these rules.

(d) "Medicare RBRVS 2005: The Physicians' Guide," published by The American Medical Association, 515 North State Street, Chicago IL, 60610, order #OPO59605CFJ, 1-800-621-8335. The publication may be purchased at a cost of \$84.95, plus \$11.95 shipping and handling as of the time of adoption of these rules.

(e) "International Classification of Diseases, ICD-9-CM 2005 Volumes 1 & 2" copyright 2004, American Medical Association, P.O. Box 930876, Atlanta GA 31193-0876, order #OP068105CFJ, 1-800-621-8335. The publication may be purchased at a cost of \$64.95, plus \$9.95 shipping and handling as of the time of adoption of these rules.

(f) "2004 Drug Topics Red Book," published by Medical Economics Company Inc., Five Paragon Drive, Montvale, NJ 07645-1742, 1-800-678-5689. The publication may be purchased at a cost of \$75.95, plus \$9.95 for shipping and handling as of the time of adoption of these rules.

(g) "Michigan Uniform Billing Manual," developed in cooperation with the American Hospital Association's National Uniform Billing Committee, published by Michigan Health and Hospital Association, Attn: UB-92 Subscriptions, 6215 West St. Joseph Highway, Lansing, MI 48917, 517-886-8366. As of the time of adoption of these rules, the cost of the publication is \$160.00, plus 6% sales tax.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10108 Definitions; A to I.

Rule 108. As used in these rules:

(a) "Act" means 1969 PA 317, MCL 418.101 et seq.

(b) "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment to the maximum fee allowed by these rules, to a provider's usual and customary charge, or, when the maximum fee is by report, to a reasonable amount. Adjust also means when a carrier re-codes a procedure, or reduces payment as a result of professional review.

(c) "Agency" means the workers' compensation agency in the department of labor & economic growth.

(d) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.

(e) "BR" or "by report" means that the procedure is not assigned a relative value unit, (RVU) or a maximum fee and requires a written description.

(f) "Carrier" means an organization which transacts the business of workers' compensation insurance in Michigan and which may be any of the following:

(i) A private insurer.

(ii) A self-insurer.

(iii) One of the funds of chapter 5 of the act.

(g) "Case" means a covered injury or illness which occurs on a specific date and which is identified by the worker's name and date of injury or illness.

(h) "Case record" means the complete health care record which is maintained by a carrier and which pertains to a covered injury or illness that occurs on a specific date.

(i) "Complete procedure" means a procedure that contains a series of steps that are not to be billed separately.

(j) “Covered injury or illness” means an injury or illness for which treatment is mandated by section 315 of the act.

(k) “Current procedural terminology”, (CPT)” means a listing of descriptive terms and identifying codes and provides a uniform nationally accepted nomenclature for reporting medical services and procedures. “Current procedural terminology” provides instructions for coding and claims processing.

(l) “Dispute” means a disagreement between a carrier or a carrier’s agent and a health care provider on the application of these rules.

(m) “Durable medical equipment” means specialized equipment which is designed to stand repeated use, which is used to serve a medical purpose, and which is appropriate for home use.

(n) “Emergency condition” means that a delay in treating a patient would lead to a significant increase in the threat to the patient’s life or to a body part.

(o) “Established patient” means a patient whose medical and administrative records for a particular covered injury or illness are available to the provider.

(p) “Expendable medical supply” means a disposable article that is needed in quantity on a daily or monthly basis.

(q) “Facility” means an entity licensed by the state in accord with 1978 PA 368, MCL 333.1101 et seq. The office of an individual practitioner is not considered a facility.

(r) “Focused review” means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.

(s) “Follow-up days” means the days of care following a surgical procedure that are included in the procedure’s maximum allowable payment, but does not include care for complications. If the surgical procedure lists “xxx” for the follow-up days, then the global concept does not apply. If “yyy” is listed for follow-up days, then the carrier shall set the global period. If “zzz” is used, then the procedure code is part of another service and falls within the global period of the other service.

(t) “Health care organization” means a group of practitioners or individuals joined together to provide health care services and includes any of the following:

- (i) Health maintenance organization.
- (ii) Industrial or other clinic.
- (iii) Occupational health care center.
- (iv) Home health agency.
- (v) Visiting nurse association.
- (vi) Laboratory.
- (vii) Medical supply company.
- (viii) Community mental health board.

(u) “Health care review” means the review of a health care case or bill, or both, by a carrier, and includes technical health care review and professional health care review.

(v) “Incidental surgery” means a surgery which is performed through the same incision, on the same day, by the same doctor of dental surgery, doctor of medicine, doctor of osteopathy, or doctor of podiatry and which is not related to diagnosis.

(w) “Independent medical examination” means an examination and evaluation which is requested by a carrier or an employee and which is conducted by a different practitioner than the practitioner who provides care.

(x) “Independent procedure” means a procedure that may be carried out by itself, separate and apart from the total service that usually accompanies it.

(y) “Industrial medicine clinic” also referred to as an “occupational health clinic” means an organization that primarily treats injured workers. The industrial medicine clinic or occupational clinic may be a health care organization as defined by these rules or may be a clinic owned and operated by a hospital for the purposes of treating injured workers.

(z) “Insured employer” means an employer who purchases workers’ compensation insurance from an insurance company that is licensed to write insurance in the state of Michigan.

History: 2000 MR 6, Eff. May 11, 2000; 2001 MR 8, Eff. May 9, 2001; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10109 Definitions; M to U.

Rule 109. As used in these rules:

(a) “Maximum allowable payment” means the maximum fee for a procedure that is established by these rules, a reasonable amount for a “by report” procedure, or a provider’s usual and customary charge, whichever is less.

(b) “Medical only case” means a case that does not involve wage loss compensation.

(c) “Medical rehabilitation” means, to the extent possible, the interruption, control, correction, or amelioration of a medical or a physical problem that causes incapacity through the use of appropriate treatment disciplines and modalities that are designed to achieve the highest possible level of post-injury function and a return to gainful employment.

(d) “Medically accepted standards” means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services ensuring that the health care is suitable for a particular person, condition, occasion, or place.

(e) “Morbidity” means the extent of illness, injury, or disability.

(f) “Mortality” means the likelihood of death.

(g) “New patient” means a patient who is new to the provider for a particular covered injury or illness and who needs to have medical and administrative records established.

(h) “Nursing home” means a nursing care facility, including a county medical care facility, created pursuant to the provisions of 1885 PA 152, MCL 36.1 et seq.

(i) “Orthotic equipment” means an orthopedic apparatus that is designed to support, align, prevent or correct deformities of, or improve the function of, a movable body part.

(j) “Pharmacy” means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

(k) “Practitioner” means an individual who is licensed, registered, or certified as used in the Michigan public health code, 1978 PA 368, MCL 333.1101 et seq.

(l) “Primary procedure” means the therapeutic procedure that is most closely related to the principal diagnosis.

(m) “Properly submitted bill” means a request by a provider for payment of health care services which is submitted to a carrier on the appropriate completed claim form with attachments as required by these rules.

(n) “Prosthesis” means an artificial substitute for a missing body part. A prosthesis is constructed by a “prosthetist”, a person who is skilled in the construction and application of a prosthesis.

(o) “Provider” means a facility, health care organization, or a practitioner.

(p) “Reasonable amount” means a payment based upon the amount generally paid in the state for a particular procedure code using data available from the provider, the carrier, or the workers’ compensation agency, health care services division.

(q) “Restorative” means that the patient’s function will demonstrate measurable improvement in a reasonable and generally predictable period of time and includes appropriate periodic care to maintain the level of function.

(r) “Secondary procedure” means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.

(s) “Specialist” means any of the following entities that are board-certified, board-eligible, or otherwise considered an expert in a particular field of health care by virtue of education, training, and experience generally accepted in that particular field:

- (i) A doctor of chiropractic.
- (ii) A doctor of dental surgery.
- (iii) A doctor of medicine.
- (iv) A doctor of optometry.
- (v) A doctor of osteopathic medicine and surgery.
- (vi) A doctor of podiatric medicine and surgery.

(t) “Subrogation” means substituting one creditor for another. An example of subrogation in workers’ compensation is when a case is determined to be workers’ compensation and the health benefits plan has already paid for the service and is requesting the workers’ compensation carrier or the provider to refund the money that the plan paid on behalf of the worker.

(u) “Technical surgical assist” means that additional payment for an assistant surgeon, referenced in R 418.10416 of these rules, is allowed for certain designated surgical procedures. The Health Care Services Manual, published annually by the workers' compensation agency, denotes a surgical procedure allowing payment for the technical surgical assist with the letter “T.”

(v) “Treatment plan” means a plan of care for restorative physical treatment services that indicates the diagnosis and anticipated goals.

(w) “Usual and customary charge” means a particular provider’s average charge for a procedure to all payment sources, and includes itemized charges which were previously billed separately and which are included in the package for that procedure as defined by these rules. A usual and customary charge for a procedure shall be calculated based on data beginning January 1, 2000.

History: 2000 MR 6, Eff. May 11, 2000; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10110 Program Information.

Rule 110. The workers’ compensation agency shall provide ongoing information regarding these rules for providers, carriers, and employees. The program shall include distribution of appropriate information materials. The health care services division shall provide periodic informational sessions for providers, billing organizations, and carriers.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10111 Advisory committee.

Rule 111. The director of the workers’ compensation agency shall appoint an advisory committee from names solicited from provider, carrier, and employee organizations. The advisory committee shall include five advocates for the concerns of providers, five advocates for the concerns of employees, and five advocates for the concerns of carriers. The director of the

workers' compensation agency shall appoint a sixteenth member to act as chair without a vote. The advisory committee shall meet not less than twice a year. Additional meetings shall be scheduled if requested by the workers' compensation agency, the chair, or a majority of the committee. Members may be removed by the director of the workers' compensation agency for cause or for missing more than one-half of the meetings in a year. The advisory committee shall perform general program oversight and assist the workers' compensation agency with the following:

(a) Annual review of the rules and the fee schedule.

(b) Development of proposed amendments to the rules and fee schedule, including payment methodologies.

(c) Review of data reports and data analyses.

(d) Review health care service disputes, resulting from a carrier's professional health care review program pursuant to these rules, that are considered by mediation, arbitration, small claims, or magistrate decisions, based on annual summary data regarding such disputes. This summary data shall be developed by the agency and shall include information regarding carriers and providers which accounts for a significant number of disputes.

(e) Review annual summary data of complaints made to the workers' compensation agency.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10112 Missed appointment.

Rule 112. A provider shall not receive payment for a missed appointment unless the appointment was arranged by the carrier or the employer. If the carrier or employer fails to cancel the appointment not less than 72 hours in advance and the provider is unable to arrange for a substitute appointment for that time, then the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of BR.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10113 Initial evaluation and management service; medical report other than inpatient hospital care.

Rule 113. (1) Except as provided in subrule (2) of this rule, and for other than inpatient hospital care, a provider shall furnish the carrier, at no additional charge, with a medical report for the initial visit, all information pertinent to the covered injury or illness if requested at reasonable intervals, and a progress report for every 60 days of continuous treatment for the same covered injury or illness.

(2) If the provider continues to treat an injured or ill employee for the same covered injury or illness at intervals which exceed 60 days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 days.

(3) The medical report of the initial visit and the progress report shall include all of the following information:

(a) Subjective complaints and objective findings, including interpretation of diagnostic tests.

(b) For the medical report of the initial visit, the history of the injury, and for the progress report, significant history since the last submission of a progress report.

(c) The diagnosis.

(d) As of the date of the medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment.

(e) Physical limitations.

(f) Expected work restrictions and length of time if applicable.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10114 Requests for existing medical records and reports.

Rule 114. (1) Nothing in these rules shall preclude a carrier, a carrier's agent, an employee, or an employee's agent from requesting additional existing medical records and reports related to a specific date of injury, in addition to those specified in R 418.10113, or those required for proper submission of a bill from a provider.

(2) If a provider is requested by the carrier to prepare and submit a special written report in addition to the medical records required by R 418.10113, R 418.10203, R 418.10204, and R 418.10901, then the provider shall bill the special report using procedure code 99199-32. For special reports up to 3 pages in length, the carrier shall reimburse the provider at \$25.00 per page.

(a) Complex report greater than 3 pages in length or record reviews shall be reimbursed on a contractual basis between the carrier and the provider.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000.

R 418.10115 Responsibilities of insured employer or self-insurer.

Rule 115. (1) An insured employer shall do all of the following:

(a) Promptly file form 100, employer's basic report of injury, to report an injury that results in 7 or more days of disability, specific loss, or death, with the workers' compensation agency and its insurer.

(b) Promptly notify its insurer of the cases that do not result in 7 or more days of disability, specific loss, or death.

(c) Promptly inform the provider of the name and address of its insurer or the designated agent of the insurer to whom health care bills should be sent.

(d) If an insured employer receives a bill, then the insured employer shall promptly transmit the provider's bill and documentation to the insurer or the designated agent of the insurer regarding a related injury or illness.

(2) For the purposes of this rule, a self-insurer shall promptly report all employee work-related injuries to their designated agent, unless they are self-administered.

(a) Unless self-administered, a self-insurer receiving a bill for a medical service shall forward the bill to their designated agent for processing and shall inform the medical provider of the address where future bills shall be sent.

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10116 Provider responsibilities.

Rule 116. (1) When a licensed facility or practitioner licensed in this state treats an injured worker for a compensable work-related injury or illness and bills the workers' compensation carrier, the carrier shall reimburse the licensed provider or facility the maximum allowable payment, or the providers' usual and customary charge, whichever is less, in accord with these rules. A provider shall do both of the following:

(a) Promptly bill the carrier or the carrier's designated agent after the date of service.

(b) Submit the bill for the medical services provided to treat an injured worker on the proper claim form, to the workers' compensation carrier or the carrier's designated agent and attach the documentation required in part 9 of these rules.

(2) If the provider has not received payment within 30 days of submitting a bill, then the provider shall resubmit the bill to the carrier and add a 3% late fee.

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003.

R 418.10117 Carrier responsibilities.

Rule 117. (1) The carrier or its designated agent shall assure that a billing form is completed properly before making payment to the licensed provider or licensed facility.

(2) A carrier may designate a third party to receive provider bills on its behalf. If a carrier instructs the provider to send the medical bills directly to the third party, then the 30-day limit of this rule begins when the third party receives the bill. The carrier is responsible for forwarding bills and medical documentation when there is a third party reviewing medical bills for the carrier.

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

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

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

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

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

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10118 Practitioner, facility, and health care organization copying charge for medical records.

Rule 118. (1) A practitioner, facility, or health care organization shall, at the request of the carrier, the carrier's agent, the employee, or the employee's agent, furnish copies of the case record for a particular covered injury or illness to the carrier, the carrier's agent, the employee, or the employee's agent. The maximum fee for providing copies shall be 45 cents per page, plus the actual cost of mailing. In addition, an administration charge for the staff's time to retrieve and copy the records shall be paid as follows:

0-15 minutes	\$2.50
Each additional 15 minute increment	\$2.50

The copying and handling charge shall apply to all reports and records, other than the original copy required pursuant to the provisions of R 418.10113, and all other reports required by these rules. The party who requests the records shall pay the copying charge.

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

(3) If an agent of a carrier or an employee requests a copy of the case record, then the agent shall indicate the date of injury. Only the records for a specific date of injury covered by the act and these rules are available as specified in subrule (1) of this rule.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10119 Facility medical audits.

Rule 119. If a facility requires that a carrier conduct an on-site audit rather than providing the medical record, then prompt payment shall occur within 30 days of completing the on-site audit. If payment does not occur within 30 days of completing the on-site audit, then the carrier shall pay a 3% late fee.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10120 Recovery of payment.

Rule 120. (1) Nothing in this rule shall preclude the recovery of payment for services and bills which may later be found to have been medically inappropriate or paid at an amount that is more than the maximum allowable payment.

(2) If the carrier makes a request to the provider for the recovery of a payment within 1 year of the date of payment and includes a statement of the reasons for the request, then the carrier may recover a payment. The carrier may recover a payment made by an employee or the carrier.

(3) Within 30 days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:

(a) If the provider is in agreement with the request, then the provider shall refund the payment to the carrier.

(b) If the provider is not in agreement with the request, then the provider shall supply the carrier with a written detailed statement of the reasons for its disagreement, together with a refund of the portion, if any, of the payment that the provider agrees should be refunded.

(4) If the carrier does not accept the reason for disagreement supplied by the provider, then the carrier may file an application for mediation or hearing as provided for in R 418.101303 and R 418.101304. Within 30 days of receipt of the provider's statement of disagreement, the carrier shall file the application for mediation or hearing with the workers' compensation agency and the carrier shall mail a copy to the provider.

(5) If, within 60 days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:

(a) File an application for mediation or hearing and mail a copy to the provider.

(b) Reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment.

(6) If, within 30 days of a final order of a magistrate, the appellate commission, or the courts, a provider does not pay in full any refund ordered, then the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10121 Rehabilitation nurse or nurse case manager visits; additional services.

Rule 121. (1) If a carrier assigns a rehabilitation nurse or nurse case manager to an injured worker's case, and the carrier requires that the nurse accompany the injured worker to provider visits, then the carrier shall reimburse the provider for the additional time.

(2) The provider may bill the rehabilitation nurse or nurse case manager visit in addition to the evaluation and management service using code RN001. The carrier shall reimburse the provider \$25.00 for RN001.

(3) Procedure code RN001 shall be reimbursed at the maximum allowable fee if the provider bills the procedure during the global period for a surgical service.

History: 2000 MR 15, Eff. Oct. 24, 2000; 2003 MR 4, Eff. Mar. 4, 2003.

PART 2. MEDICINE**R 418.10201 Medicine services; description.**

Rule 201. Medicine services shall be described with procedure codes 90281-99199.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10202 Evaluation and management services.

Rule 202. (1) Procedure code 97010 performed in conjunction with an evaluation and management office visit shall not be reimbursed as a separate procedure.

(2) Minor medical and surgical supplies routinely used by the practitioner or health care organization in the office visit shall not be billed separately.

(3) Supplies, or other services, over and above those usually incidental to an office visit or other outpatient visit for the evaluation and management of a patient shall be billed separately under procedure code 99070.

(4) If an office visit is performed outside of the provider's normal business hours, the provider may bill the add on procedure codes describing an office visit performed after hours or on Sundays or holidays. A provider may bill add on procedure code 99050 in addition to the evaluation and management service, if a service is rendered between the hours of 6:00 p.m. and 7:00 a.m., Monday through Saturday. A provider may bill add on procedure code 99054 if a service is rendered on Sundays or holidays until 7:00 a.m. of the following regular working day.

(5) A procedure that is normally part of an examination or evaluation shall not be billed independently. Range of motion shall not be reimbursed as a separate procedure in addition to the evaluation and management service unless the procedure is medically necessary and appropriate for the injured worker's condition and diagnosis.

(6) The maximum allowable payment for the evaluation and management service shall be determined by multiplying the relative value unit, RVU, assigned to the procedure code, times the conversion factor listed in the reimbursement section of these rules.

(7) The level of an office visit or other outpatient visit for the evaluation and management of a patient is not guaranteed and may change from session to session. The level of service shall be consistent with the type of presenting complaint and supported by documentation in the record.

(8) Procedure codes 99455 and 99456 describing work-related or medical disability evaluation services shall not be used to describe an evaluation and management service for treating a work-related injury or illness. Procedure codes 99201-99350 shall be used to describe the practitioner's medical treatment of an injured worker.

(9) The carrier shall not reimburse the provider for procedure codes 90782-90799, administration of therapeutic injections, if billed in conjunction with an evaluation and management service. The medication administered in the therapeutic injection shall be billed using procedure code 99070 and shall be identified with the national drug code number. The provider shall be reimbursed at the average wholesale price of the drug. If the provider does not bill an evaluation and management service, then the appropriate procedure code describing the administration of the drug may be billed. The administered drug is billed additionally and is payable at the average wholesale price of the drug.

(10) The provider may bill immunization procedure codes in addition to the evaluation and management procedure code. If the provider bills an immunization, then the vaccine is described with procedure codes 90476-90748, and the administration of the vaccine is described with procedure code 90471 or 90472. The carrier shall reimburse the vaccine at the average wholesale price of the vaccine plus the cost of administration billed with procedure codes 90471 or 90472.

(11) Procedure code 76140, x-ray consultation, shall not be paid to the provider in addition to the evaluation and management service, to review x-rays taken elsewhere. The carrier shall not pay for review of an x-ray by a practitioner other than the radiologist providing the written report or the practitioner performing the complete radiology procedure.

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2004 MR 5, Eff. Feb. 20, 2004.

R 418.10203 Office visit or other outpatient visit for evaluation and management of patient in conjunction with ongoing osteopathic manipulative treatment or chiropractic manipulative treatment.

Rule 203. (1) The carrier shall reimburse for the initial evaluation and management examination billed by the provider before initiating chiropractic or osteopathic manipulation. The carrier shall also reimburse for osteopathic manipulative treatment or chiropractic manipulative treatment if the treatment is initiated on the same date of service.

(2) All of the following provisions apply to ongoing osteopathic manipulative treatment:

(a) Osteopathic manipulative treatment procedure codes include pre-manipulative patient evaluation. The physician may bill a separate evaluation and management service using modifier code -25. The carrier shall only reimburse the service if the documentation provided supports significant change of signs and symptoms or the evaluation of another work related problem not included in the procedure or service that required the encounter. The physician shall document the rationale for the significant other service in the record.

(b) Osteopathic manipulations are to be billed using procedure codes 98925-98929.

(3) All of the following provisions apply to ongoing chiropractic manipulative treatment:

(a) The chiropractic manipulative treatment codes include a pre-manipulation patient evaluation. The provider may report a separate evaluation and management service using modifier -25 to designate a separate identifiable service. The carrier shall reimburse the evaluation and management service only when the provider documents significant change of signs and symptoms or the evaluation of another work related problem not included in the procedure or service that required the encounter. The provider shall document the rationale for the significant other service in the record.

(b) The carrier shall reimburse chiropractic manipulative treatment when the provider bills the service with procedure codes 98940-98942.

(4) If either a doctor of osteopathy or a doctor of chiropractic, conducts a periodic re-evaluation, then a report of the evaluation shall accompany the bill. A periodic re-evaluation report shall include all of the following information:

(a) A description of the evaluation of function in measurable terms based on physical findings and problem identification.

(b) A goal statement.

(c) A treatment plan.

(d) Physical and functional improvement in measurable terms that has occurred in relationship to the diagnosis for which the treatment was prescribed.

(e) The likelihood of continued improvement if treatment is continued.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10204 Office visit or other outpatient visit; evaluation and management of patient's progress in physical treatment.

Rule 204. (1) An office visit or other outpatient visit for the evaluation and management of a patient's progress in physical treatment shall only be billed when there is a change of signs or symptoms and when the referring or treating practitioner provides supporting documentation as described in subrule (2) of this rule. The supporting documentation shall indicate that it is medically appropriate for the practitioner to make the evaluation.

(2) Documentation shall include the referring or treating practitioner's statement that an office visit was medically necessary. In addition, a report shall state that an examination was conducted and shall set forth the specific findings by the practitioner, including all of the following:

(a) A description of the evaluation of function in measurable terms based on physical findings and problem identification.

(b) A goal statement.

(c) A treatment plan.

(d) Physical and functional improvement in measurable terms that has occurred in relationship to the diagnosis for which physical medicine treatment was prescribed.

(e) The likelihood of continued improvement if physical medicine treatment were continued.

(3) The report required pursuant to subrule (2) of this rule may be used to meet the reporting requirements of physical medicine services provided in these rules.

(4) The office visit or other outpatient visit for the evaluation and management of a patient shall include the evaluation procedures that are appropriate to the diagnosis.

(5) Nothing in this rule pertains to office visits or other outpatient visits for the evaluation and management of a patient that are not related to physical treatment.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10205 Consultation services.

Rule 205. (1) An attending physician, carrier, third-party administrator, or the injured worker may request a consultation. A physician specialist shall provide consultations using procedure codes 99241-99275 to describe the service.

(2) The carrier may request a provider other than the treating practitioner to perform a confirmatory consult. The physician specialist performing the confirmatory consult shall bill procedure codes 99271-99275, defined in "Physicians' Current Procedural Terminology (CPT[®])" and shall be subject to the maximum payment allowance as defined in the reimbursement section of these rules.

(3) If a specialist performs diagnostic procedures or testing in addition to the consultation, then the specialist shall bill the appropriate procedure code from “Physicians’ Current Procedural Terminology (CPT®). The carrier shall reimburse the testing procedures in accordance with these rules.

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10206 Emergency department evaluation and management visit.

Rule 206. An emergency physician shall use emergency department evaluation and management service procedure codes to report an emergency department visit.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10207 Mental health services.

Rule 207. (1) A psychiatrist, only, shall use procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, and 90829 to describe treatment of a mental health condition, and shall not be billed in conjunction with, 99201-99499, an evaluation and management service.

(2) A psychiatrist shall use procedure codes 90801 and 90802 to describe a psychiatric diagnostic interview. A psychiatric consultation may be reported with procedure codes 99214-99263 and shall be limited to evaluation and does not include psychiatric treatment.

(3) An individual performing psychological testing shall report the services using procedure codes 96100-96117.

(4) Mental health providers shall use the following modifiers to describe the practitioner providing the health services:

- (a) -AH, for services provided by a licensed psychologist.
- (b) -AL, for services provided by a limited licensed psychologist.
- (c) -AJ, for services provided by a certified social worker.
- (d) -LC, for services provided by a licensed professional counselor.
- (e) -CS, for services provided by a limited licensed counselor.
- (f) -MF, for services provided by a licensed marriage and family therapist.
- (g) -ML, for services provided by a limited licensed marriage and family therapist.

History: 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001.

R 418.10208 Vision services.

Rule 208. (1) A medical diagnostic eye evaluation by a practitioner is an integral part of all ophthalmology services.

(2) Intermediate and comprehensive ophthalmological services include medical diagnostic eye evaluation and services, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, determination of refractive state, tonometry, or motor evaluation. These procedures shall not be billed in conjunction with procedure codes 92002, 92004, 92012, and 92014.

(3) Only an ophthalmologist or a doctor of optometry shall use procedure codes 92002, 92004, 92012, and 92014.

(4) A doctor of optometry shall use procedure codes 92002-92287 to describe services.

(5) An employer is not required to reimburse or cause to be reimbursed charges for an optometric service unless that service is included in the definition of practice of optometry under section 17401 of the Michigan Public Health Code, Act 368 of 1978, as amended, being § 333.17401 of the Michigan compiled laws, as of May 20, 1992.

(6) Suppliers of vision and prosthetic optical procedures shall use the appropriate procedure code V0000-V2999 listed in Medicare's National Level II Codes as referenced in 418.10107 (2) to describe services provided.

History: 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001.

R 418.10209 Hearing services.

Rule 209. (1) A provider performing a comprehensive otorhinolaryngologic evaluation shall report the service using the appropriate evaluation and management service.

(2) A provider shall not report an otoscope, a rhinoscopy, or a tuning fork test in addition to a comprehensive ear evaluation or office visit.

(3) A provider performing special otorhinolaryngologic procedures, in addition to the evaluation, shall report those services using procedure codes 92507-92599.

(4) An audiologist and a speech therapist shall use procedure codes 92502-92599. An audiologist, a speech therapist, and a speech and hearing center shall use procedure codes 92502-92599 and procedure codes V5030-V5240 for hearing aid services.

(5) Hearing aid suppliers shall use the appropriate procedure code V5008-V5230 listed in Medicare's National Level II Codes as referenced in 418.10107(2) to describe services provided.

History: 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001.

R 418.10212 Physical and occupational therapy; physical medicine services.

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

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

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

- (a) A doctor of medicine.
- (b) A doctor of osteopathic medicine and surgery.
- (c) A doctor of dental surgery.
- (d) A doctor of chiropractic.
- (e) A doctor of podiatric medicine and surgery.
- (f) A physical therapist.
- (g) An occupational therapist.

(4) Only a licensed physical therapist, certified occupational therapist, or licensed practitioner may use procedure codes 97001-97004 to describe the physical medicine and rehabilitation evaluation services. Only a certified occupational therapist or a licensed physical therapist shall perform codes WC500-WC600 for job site evaluation.

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

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

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

(6) A provider shall report procedure code 97750 to describe a functional capacity evaluation. A maximum of 24 units or 6 hours shall be reimbursed by the carrier for the initial evaluation. No more than 4 additional units shall be billed for a re-evaluation occurring within 2 months.

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

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

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

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

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

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

(b) Procedure 97010 shall not be reimbursed if the practitioner bills an evaluation and management service on the same date. Procedure code 97010 shall be used to bill hot or cold agents for any of the following reasons:

- (i) Hot packs.
- (ii) Hydrocollator packs.
- (iii) Heat lamps.
- (iv) Medconsonolator.
- (v) Fluidotherapy.
- (vi) Cryotherapy agents.
- (vii) Ice melts and ice massage.
- (viii) Vaporizing liquids.
- (ix) Refrigerated units.
- (x) Chemical packs.
- (xi) Cold packs.

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

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

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

(f) Electrical stimulation shall include the electrodes.

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

History: 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001.

R 418.10213 Splints

Rule 213. (1) Extremity splints may be prefabricated, off-the-shelf, custom-made, or custom-fit.

(2) A provider shall report prefabricated, off-the-shelf splints using procedure code A4570 or 99070. If a certified occupational therapist or physical therapist needs to adapt a splint, then the therapist shall use modifier -22. A report shall be submitted to describe the nature of the adaptation.

(3) If a certified occupational therapist or physical therapist constructs an extremity splint, then the therapist shall bill the service using procedure code L3999. The carrier shall reimburse the splint as a by report procedure. The provider shall include the following information with the bill:

- (a) A description of the splint.
- (b) The time taken to construct or modify the splint.
- (c) The charge for materials, if applicable.

History: 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001.

R 418.10214 Orthotic and prosthetic equipment.

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

- (a) A doctor of medicine.
- (b) A doctor of osteopathic medicine and surgery.
- (c) A doctor of chiropractic.
- (d) A doctor of podiatric medicine and surgery.

(2) Orthotic equipment may be any of the following:

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

(3) A non-custom supply shall be billed using procedure code 99070 or A4570 for a prefabricated splint.

(4) A board-certified orthotist or prosthetist who is certified by the American board for certification in orthotics and prosthetics, incorporated shall bill orthoses and prostheses that are custom-fabricated, molded to the patient, or molded to a patient model. In addition, a doctor of podiatric medicine and surgery may bill for a custom-fabricated or custom-fit, or molded patient model foot orthosis using procedure codes L3000-L3649.

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

(6) Maximum allowable payments for L-code procedures are listed in R 418.101504. If an L-code procedure does not have an assigned maximum allowable payment, then the procedure shall be by report, "BR."

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

History: 2000 MR 6, Eff. May 11, 2000; 2004 MR 5, Eff. Feb. 20, 2004.

PART 4. SURGERY

R 418.10401 Global surgical procedure.

Rule 401. (1) A global surgical procedure shall include all of the following:

(a) All office, home, and hospital visits occurring after the physician determines the need for surgery or those visits that are related to, or are preparatory to, the surgery. A consult to determine the need for surgery is not considered part of the global procedure.

(b) Surgery, intra-operative procedures, and local anesthetic.

(c) Normal uncomplicated care occurring during the follow-up day period indicated for the surgical procedure.

(d) Removal of sutures shall always be included in the surgical procedure when removed by the same practitioner or by a practitioner in the same facility or health care organization where the initial surgery occurred.

(e) Operative report.

(2) Intra-operative procedures shall include any of the following:

(a) Local infiltration of medication at the time of operation.

(b) Suture removal by the operating physician.

(c) Surgical approach.

(d) Wound culture.

(e) Intra-operative photos and video imaging.

(f) Isolation of neurovascular structure.

(g) Simulation of nerves for identification.

(h) Wound irrigation.

(i) Intra-operative supervision and interpretation of imaging by the operating surgeon.

(j) Placement and removal of surgical drain or suction device.

(k) Wound closure.

(l) Application of the initial dressing, splint, or cast, including skin traction, except if specifically excluded from the package.

(m) All intra-operative services performed by the principal surgeon that are a necessary part of the primary operation.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10403 Complication, exacerbation, recurrence, or presence of other disease or injury.

Rule 403. (1) If a complication, exacerbation, recurrence, or the presence of other disease or injury exists that requires additional services, then the services shall be reported and identified by the appropriate procedure code.

(2) Reimbursement shall only be made for services related to, or resulting from, the covered work injury.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10404 Follow-up care occurring during global service.

Rule 404. (1) Follow-up care for a diagnostic procedure shall refer only to the days required to recover from the diagnostic procedure and not the treatment of the underlying condition.

(2) Follow-up care for therapeutic surgical procedures includes only that care which is usually part of the surgical service. Complications, exacerbations, recurrence, or the presence of other compensable diseases or injuries requiring additional services should be reported with the identification of appropriate procedures. The follow-up days for the surgical procedures are

adopted from the “Medicare RBRVS The Physicians Guide” as referenced in R 418.10107(d). The follow-up days for each surgical procedure are identified in the "global" column in the manual published by the workers’ compensation agency separate from these rules.

(a) If a carrier requests the surgeon to see an injured worker during the global service period for the purpose of job restrictions, job adjustments, or return to work, then the visit shall not be considered part of the global surgery package. If the carrier requests the visit, then the carrier shall prior authorize the visit assigning an authorization number. The provider shall bill the visit using procedure 99455 and modifier –32, including the authorization number in box 23 of the CMS 1500 form. The carrier shall not deny a prior authorized visit and shall reimburse the provider for the prior authorized visit. The maximum allowable payment for 99455-32 shall be listed in rule R 418.101502.

(b) The medical record shall reflect job adjustments, job restrictions or limitations, or return to work date and the provider shall include the medical record with the bill.

(c) If an insured employer requests the surgeon to see an injured worker during the global surgery period for the purpose of job adjustments, restrictions, or return to work, then the employer shall obtain the prior authorization number from the carrier for the visit.

(3) Hospital follow-up care or a hospital visit by the practitioner responsible for the surgery shall be considered part of the surgical follow-up days listed for the procedure and shall not be paid as an independent procedure.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10405 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10406 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10407 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10410 Incidental surgeries.

Rule 410. The carrier shall not pay a bill for an incidental surgery which is not part of the primary procedure performed, and for which there is no diagnostic evidence or relationship to the covered work injury.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10411 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10415 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10416 Assistant surgeon.

Rule 416. (1) The carrier shall reimburse for an assistant surgeon service for those surgical procedures preceded by a “T,” in the health care services manual published separate from these rules.

(2) One of the following shall provide assistant surgeon services:

- (a) A doctor of dental surgery.
- (b) A doctor of osteopathy.
- (c) A doctor of medicine.
- (d) A doctor of podiatry.
- (e) A physician’s assistant.
- (f) A nurse with a specialty certification.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10417 Ophthalmological surgical procedures.

Rule 417. Ophthalmological surgical procedure codes for the removal of a foreign body include topical anesthesia, fluorescein staining, and lavage.

History: 2000 MR 6, Eff. May 11, 2000.

PART 5. RADIOLOGY, RADIATION THERAPY, AND NUCLEAR MEDICINE

R 418.10501 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10502 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10503 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

PART 7. DENTAL

R 418.10701 Scope.

Rule 701. (1) Dental services, related to, or resulting from, a covered work-related injury are covered under these rules. Incidental dental services are not covered.

(2) A dental provider shall bill services on a standard American dental claim form. The workers’ compensation agency shall publish a copy of the claim form and instructions for completion separate from these rules in the health care services manual.

(3) Dental services shall be reimbursed at either the dentist’s usual and customary fee or reasonable fee, whichever is less.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

PART 9. BILLING

SUBPART A. PRACTITIONER BILLING

R 418.10901 General information.

Rule 901. (1) All health care practitioners and health care organizations, as defined in these rules, shall submit charges on the proper claim form as specified in this rule. Copies of the claim forms and instruction for completion for each form shall be published separate from these rules in a manual distributed by the health care services division of the workers' compensation agency. Charges shall be submitted as follows:

- (a) A practitioner shall submit charges on the CMS1500 claim form.
- (b) A doctor of dentistry shall submit charges on a standard dental claim form approved by the American dental association.
- (c) A pharmacy, other than an inpatient hospital, shall submit charges on an invoice or a pharmacy universal claim form.
- (d) A hospital-owned occupational, industrial clinic, or office practice shall submit charges on the CMS 1500 claim form.
- (e) A hospital billing for a practitioner service shall submit charges on a CMS 1500 claim form.
- (f) Ancillary service charges shall be submitted on the CMS 1500 claim form for durable medical equipment and supplies, L-code procedures, ambulance, vision, and hearing services. Charges for home health services shall be submitted on the UB-92 claim form.
- (g) A shoe supplier or wig supplier shall submit charges on an invoice.
- (2) A provider shall submit all bills to the carrier within 1 year of the date of service for consideration of payment, except in cases of litigation or subrogation.
- (3) A properly submitted bill shall include all of the following appropriate documentation:
 - (a) A copy of the medical report for the initial visit.
 - (b) An updated progress report if treatment exceeds 60 days.
 - (c) A copy of the initial evaluation and a progress report every 30 days of physical treatment, physical or occupational therapy, or manipulation services.
 - (d) A copy of the operative report or office report if billing surgical procedure codes 10040-69990.
 - (e) A copy of the anesthesia record if billing anesthesia codes 00100-01999.
 - (f) A copy of the radiology report if submitting a bill for a radiology service accompanied by modifier -26. The carrier shall only reimburse the radiologist for the written report, or professional component, upon receipt of a bill for the radiology procedure.
 - (g) A report describing the service if submitting a bill for a "by report" procedure.
 - (h) A copy of the medical report if a modifier is applied to a procedure code to explain unusual billing circumstances.

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 4, Eff. Feb 10, 2005.

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

Rule 902. (1) The provider shall not bill the carrier for procedure codes 90782-90799, administration of therapeutic injections, if billed in conjunction with an evaluation and management procedure code. If an evaluation and management procedure code, 99201-99499, is not listed, then procedure codes 90782-90799 may be billed to describe the administration of the medication.

(2) The injection medication shall be billed with either 99070, the unlisted drug and supply code from physicians' current procedural terminology, (CPT®), or the specific J-code procedure from Medicare's National Level II Codes as adopted by reference in R 418.10107.

(3) The provider shall list the NDC or national drug code for the medication in box 19 or 24K of the CMS 1500.

(4) The carrier shall reimburse the medication at average wholesale price, (AWP) according to the Redbook, as adopted by reference in R 418.10107.

(5) If the provider does not list the national drug code for the medication, the carrier shall reimburse the medication using the least costly NDC listed by Redbook for that medication.

History: 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10904 Procedure codes and modifiers.

Rule 904. (1) A health care service shall be billed with procedure codes adopted from "Physicians' Current Procedural Terminology (CPT®)" or "HCPCS, Medicare's National Level II Codes," as referenced in R 418.10107. Procedure codes from "Physicians' Current Procedural Terminology (CPT®)" shall not be included in these rules, but shall be listed in a separate manual published by the workers' compensation agency. Refer to "Physicians' Current Procedural Terminology (CPT®)" for standard billing instructions, except where otherwise noted in these rules. A provider billing services described with procedure codes from "Medicare's National Level II Codes" shall refer to the publication as adopted by reference in R 418.10107 for coding information.

(2) The following ancillary service providers shall bill codes from "HCPCS, Medicare's National Level II Codes," as adopted by reference in R 418.10107, to describe the ancillary services:

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

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

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

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

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

Table 10904
Modifier Codes

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

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10905 Billing for physical and occupational therapy.

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

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

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

(3) Procedures 97504 and 97520 shall only be reimbursed when billed by an occupational or physical therapist.

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

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10907 Billing codes for site of service and type of service.

Rule 907. (1) A practitioner, other than a dentist, when billing practitioner services, shall identify the site of service and type of service with numerical codes consistently used in the

industry. The health care services division of the workers' compensation agency shall publish the numerical codes in the Health Care Services Manual separate from these rules.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10909 Billing for home health services.

Rule 909. (1) Services provided by a home health agency are considered ancillary services requiring a physician's prescription certifying medical necessity. A copy of the prescription shall be attached to the bill.

(2) A home health agency shall submit charges to the workers' compensation carrier using the UB-92 claim form.

(3) A home health agency shall use procedure codes from "HCPCS, Medicare's National Level II Codes" adopted by reference in R 418.10107 to identify services provided.

(4) A home health agency may not bill for the services of a social worker unless the certified social worker is providing medically necessary therapeutic counseling.

(5) A home health agency may bill supplies with 99070, the unlisted CPT[®] code for miscellaneous supplies, or the appropriate supply code from "Medicare's National Level II Codes HCPCS" as adopted by reference in R 418.10107.

(6) When a procedure code is described by "HCPCS, Medicare's Level II" as per diem, the "by report" service is reimbursed per visit. When "HCPCS, Medicare's Level II" describes a service as time-based the service is "by report," and the procedure is reimbursed according to the time provided.

History: 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10911 Billing requirements for ancillary services.

Rule 911. (1) A bill for the following ancillary services shall include a copy of a written prescription by a licensed practitioner. Documentation of a prescription drug or medical supply in the clinical record shall constitute the prescription for services dispensed in a practitioner's office or in a health care organization.

(a) Prescription medications.

(b) Medical supplies and equipment, except when dispensed by a facility or health care organization.

(c) Hearing aids, shoes, and wigs.

(d) Home health services.

(e) Orthoses and prostheses.

(f) Physical and occupational therapy.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10912 Billing for prescription medications.

Rule 912. (1) Prescription drugs may be dispensed to an injured worker by either an outpatient pharmacy or a health care organization as defined in these rules. These rules shall apply to the pharmacy dispensing the prescription drugs to an injured worker only after the pharmacy has either written or oral confirmation from the carrier that the prescriptions or supplies are covered by workers' compensation insurance.

(2) When a generic drug exists, the generic drug shall be dispensed. When a generic drug does not exist, the brand name drug may be dispensed. A physician may only write a prescription for "DAW", or dispense as written, when the generic drug has been utilized and found to be ineffective or has caused adverse effects for the injured worker. A copy of the medical record documenting the medical necessity for the brand name drug shall be submitted to the carrier.

(3) A bill or receipt for a prescription drug from an outpatient pharmacy, practitioner, or health care organization shall be submitted to the carrier and shall include the name, address, and social security number of the injured worker. An outpatient pharmacy shall bill the service using the universal pharmacy claim form or an invoice and shall include the national association board of pharmacy identification number and the serial number of the prescription drug.

(4) A health care organization or physician office dispensing the prescription drug shall bill the service on the CMS 1500 claim form. Procedure code 99070 shall be used to code the service and the national drug code shall be used to describe the drug.

(5) If an injured worker has paid for a prescription drug for a covered work illness, then the worker may send a receipt showing payment along with the drug information to the carrier for reimbursement.

(6) An outpatient pharmacy or health care organization shall include all of the following information when submitting a bill for a prescription drug to the carrier:

(a) The brand or chemical name of the drug dispensed.

(b) The manufacturer or supplier's name and the NDC, or national drug code from the "Red Book" as adopted by reference in R 418.10107.

(c) The dosage, strength, and quantity dispensed.

(d) The date the drug was dispensed.

(e) The physician prescribing the drug.

(7) A practitioner or a health care organization, other than an inpatient hospital, shall bill WC700 to describe the dispense fee for each prescription drug. A provider will only be reimbursed for 1 dispense fee for each prescription drug in a 10-day period. A dispense fee shall not be billed with "OTC"s, over-the-counter drugs.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10913 Billing for durable medical equipment and supplies.

Rule 913. (1) A bill for a medical supply or durable medical equipment shall be accompanied by a prescription, except if dispensed by a health care organization or a facility. The provider shall bill the appropriate code from the "Medicare National Level II HCPCS Codes" as adopted by reference in R 418.10107.

(2) A bill for durable medical equipment shall include the procedure code, the manufacturer's name, the model number if available and the serial number. Bills for durable medical equipment may be for rental or purchase dependent upon requirements of the injured worker.

(3) A bill for an expendable medical supply shall include the brand name and the quantity dispensed.

(4) A bill for a miscellaneous supply, for example; either a wig, shoes, or shoe modification, shall be submitted on an invoice if the supplier is not listed as a health care professional.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.10915 Billing for anesthesia services.

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

(2) An anesthesia service may be administered by either an anesthesiologist, anesthesia resident, a certified registered nurse anesthetist, or a combination of a certified registered nurse anesthetist, and a physician providing medical direction or supervision. When billing for both the anesthesiologist and a certified registered nurse anesthetist, the anesthesia procedure code shall be listed on 2 lines of the CMS 1500 with the appropriate modifier on each line.

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

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

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

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

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

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

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

(a) A licensed doctor of dental surgery.

(b) A licensed doctor of medicine.

(c) A licensed doctor of osteopathy.

(d) A licensed doctor of podiatry.

(e) A certified registered nurse anesthetist.

(f) A licensed anesthesiology resident.

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

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

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

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

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

History: 20400 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10916 Billing for minor practitioner services performed in an outpatient hospital setting.

Rule 916. (1) This rule applies to the practitioner component of minor procedures that can safely be performed in a setting other than an outpatient hospital. If a practitioner or health care organization submits a bill for a procedure code listed in table 10916 in the outpatient hospital setting, then modifier code -26 shall be added to the procedure code and the carrier shall pay the maximum allowable fee listed in the manual for the professional portion of the procedure, or, if the professional portion is not listed, then the carrier shall pay 40% of the maximum allowable fee for the procedure.

(2) This rule shall not apply to any of the following instances:

(a) During an inpatient, observation stay, or services appropriately performed in the emergency room department.

(b) For procedures performed during an outpatient surgery.

(c) If procedures from table 10916 are performed during the course of an outpatient setting in conjunction with a procedure that is appropriately performed in the outpatient setting; for example, a radiology procedure with a myelogram or outpatient surgery.

(3) This rule shall not apply if the procedure is performed by an emergency room physician granted privileges by the hospital to practice in the emergency room.

(4) Table 10916 reads as follows:

10060	20665-20670	30901	65205-65222	92531-92599
10120	23065	40800	67700	93740
10140	23330	40804	67715-67805	94010-95065
10160	24065	40820	67810-67825	95115-95199
11000	24200	41000-41005	67938	95180
11040	25065	41800-41805	69000	95860-95904
11100-11101	26010	42300	69020	95930-95937
11720-11750	27040	42310	70030-70360	98925-98943
11900-11901	27086	45300	70450-71030	99195
12001-12004	27323	45330	71100-72220	99201-99215
15860	27613	46050	73000-74420	99241-99245
16000	28001	50398	74400-74420	90801-90815
16020-16030	28190	51000	78300-78699	
20500	30000-30100	51700-51710	90901-90911	
20520	30200-30210	53600-53661	92002-92014	
20550-20610	30300	53670-53675	92230-92504	

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003.

R 418.10918 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2002 MR 1, Eff. Jan. 11, 2002.

R 418.10920 Billing for supplementary radiology supplies.

Rule 920. (1) If a description of a diagnostic radiology procedure includes the use of contrast materials, then those materials shall not be billed separately as they are included in the procedure.

(2) A radiopharmaceutical diagnostic low osmolar contrast materials and paramagnetic contrast materials shall only be billed when “Current Procedural Terminology” billing instructions indicate supplies shall be listed separately.

(3) A supply for a radiology procedure shall be coded as provided in this rule. A provider shall include an invoice documenting the wholesale price of the contrast material used and the provider shall be reimbursed the wholesale price of the contrast material.

Code	Descriptor
A4641	Supply of radiopharmaceutical diagnostic imaging agent
A4644	Supply of low osmolar contrast material (100-199 mgs. of iodine)
A4645	Supply of low osmolar contrast material (200-299 mgs. of iodine)
A4656	Supply of low osmolar contrast material (300-399 mgs. of iodine)

History: 2000 MR 6, Eff. May 11, 2000.

PART 9. BILLING

SUBPART B. FACILITY BILLING

R 418.10921 Facility billing.

Rule 921. (1) Except for a freestanding surgical outpatient facility, a licensed facility as defined in these rules shall submit facility charges on a UB-92 claim form to the carrier. A copy of the UB-92 form shall be published separate from these rules in a manual distributed by the health care services division of the agency. The Michigan uniform billing manual referenced in these rules contains instructions for facility billing.

(2) A facility billing for a practitioner service shall bill charges on the CMS 1500 claim form.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10922 Hospital billing instructions.

Rule 922. (1) A hospital billing for the facility portion of emergency department, outpatient, and inpatient services, shall bill facility charges on the UB-92 national uniform billing claim form and shall include revenue codes, ICD.9.CM coding, and CPT[®] codes for surgical, radiological, laboratory, medicine, and evaluation and management services.

(2) Procedures listed in Table 10922 can safely be performed in an outpatient setting other than an outpatient hospital. When procedures listed in Table 10922 are performed in the outpatient hospital setting, the carrier shall pay the maximum allowable fee listed in the manual for the technical component of the procedure, or 60% of the maximum allowable fee if the technical component is not listed. This rule does not apply to any of the following:

(a) During the first 10 days of care commencing for an injury.

(b) During an inpatient or observation stay or services appropriately performed in the emergency room department.

(c) Procedures performed during the time of an outpatient surgery.

(d) If a procedure included in Table 10922 is combined with another procedure not found on Table 10922; for example, a radiology procedure with a myelogram or outpatient surgery.

(3) Table 10922 reads as follows:

10060	20665-20670	30901	65205-65222	92531-92599
10120	23065	40800	67700	93740
10140	23330	40804	67715-67805	94010-95065
10160	24065	40820	67810-67825	95115-95199
11000	24200	41000-41005	67938	95180
11040	25065	41800-41805	69000	95860-95904
11100-11101	26010	42300	69020	95930-95937
11720-11750	27040	42310	70030-70360	98925-98943
11900-11901	27086	45300	70450-71030	99195
12001-12004	27323	45330	71100-72220	99201-99215
15860	27613	46050	73000-74020	99241-99245
16000	28001	50398	74400-74420	90801-90815
16020-16030	28190	51000	78300-78699	
20500	30000-30100	51700-51710	90901-90911	
20520	30200-30210	53600-53661	92002-92014	
20550-20610	30300	53670-53675	92230-92504	

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

(5) A hospital shall bill the physical, occupational, and speech therapy services on the UB-92 national uniform billing claim form and the hospital shall be paid according to the hospital's payment ratio. The hospital shall provide the carrier with the initial evaluation and progress notes every 30 days.

(6) A hospital system-owned office practice shall not bill facility fees

(7) A hospital or hospital system-owned industrial or occupational clinic providing occupational health services shall not bill facility fees.

History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003.

R 418.10923 Hospital billing for practitioner services.

Rule 923. (1) A hospital billing for practitioner services, including a certified registered nurse anesthetist, a physician, a nurse who has a specialty certification, and a physician's assistant, shall submit bills on a CMS 1500 form and the hospital shall use the appropriate procedure codes adopted by these rules. A hospital shall bill for professional services provided in the hospital clinic setting as practitioner services on a CMS 1500 form using outpatient hospital for the site of service. A hospital or hospital system-owned office practice shall bill all office services as practitioner services on a CMS 1500 form using office or clinic for the site of service. A hospital or hospital system-owned industrial or occupational clinic providing occupational health services for injured workers shall bill all clinic services as practitioner services on a CMS 1500 using office or clinic for the site of service. A hospital or hospital system-owned industrial or occupational clinic shall not use emergency department evaluation and management procedure codes. Radiology and laboratory services may be billed as facility services on the UB-92.

(2) A hospital billing for the professional component of a medical service, excluding physical medicine, occupational medicine, or speech and hearing services shall bill the service on a CMS 1500 claim form adding modifier -26 identifying the bill is for the professional component of the

service. The bill shall indicate outpatient hospital for the site of service. The carrier shall pay the maximum allowable fee listed in the manual for the professional component of the procedure. If the professional component is not listed, then the carrier shall pay 40% of the maximum allowable fee.

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

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

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.10923B Billing for freestanding surgical outpatient facility,(FSOF).

Rule 923B (1) A freestanding surgical outpatient facility (FSOF) shall be licensed by the department of public health, bureau of health systems, under part 208 of the code. The owner or operator of the facility shall make the facility available to other physicians, dentists, podiatrists or providers who comprise its professional staff.

(a) When a surgery procedure is appropriately performed in the freestanding surgical outpatient facility and Medicare has not assigned a grouper number for that procedure, the procedure shall be considered by report. The freestanding surgical outpatient facility shall be reimbursed either the usual and customary charge or reasonable charge, whichever is less for the procedure.

(2) Billing instructions in this rule do not apply to a hospital-owned freestanding surgical outpatient facility billing with the same tax identification number as the hospital.

(3) A freestanding surgical outpatient facility, licensed by the state, shall bill the facility services on the CMS 1500 claim form and shall include modifier SG to identify the service as the facility charge. The place of service shall be "24." The appropriate HCPCS or CPT® procedure code describing the service performed shall be listed on separate lines of the bill.

(4) Modifier 50, generally indicating bilateral procedure is not valid for the FSOF claim. Procedures performed bilaterally shall be billed on two separate lines of the claim form and shall be identified with modifiers, LT for left and RT for right.

(5) A freestanding surgical outpatient facility shall only bill for outpatient procedures which, in the opinion of the attending physician, can be performed safely without requiring inpatient overnight hospital care and are exclusive of such surgical and related care as licensed physicians ordinarily elect to perform in their private offices.

(6) The CPT® procedure code billed by the facility is classified according to 1 of 9 groupers, as determined by center for Medicare and Medicaid services. The grouper number for each procedure code is published in the federal register.

(7) The payment for the surgical code includes the supplies for the procedure.

(8) Laboratory procedures, durable medical equipment, radiology services, and items implanted into the body that remain in the body at discharge from the facility may be billed separately.

(9) The facility shall bill implant items with the unlisted CPT® drug and supply code, 99070. A report listing a description of the implant and a copy of the facility's cost invoice shall be included with the bill. Some examples of implant items are plates, pins, screws, mesh.

(10) When radiology procedures are performed intra-operatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and postoperative radiology services may be globally billed.

(11) At no time shall the freestanding surgical outpatient facility bill for practitioner services on the facility bill.

History: 2005 MR 4, Eff. Feb 10, 2005

R 418.10924 Rescinded.

History: 2000 MR 6, Eff. May 11, 2000; rescinded 2003 MR 4, Eff. Mar. 4, 2003.

R 418.10925 Billing requirements for other licensed facilities.

Rule 925. (1) A licensed facility, other than a hospital or freestanding surgical outpatient facility, shall bill the facility services on the UB-92 national uniform billing claim form and shall include the revenue codes contained in the Michigan Uniform Billing Manual, ICD-9-CM coding for diagnoses and procedures, and CPT® procedure codes for surgical, radiological, laboratory, and medicine and evaluation and management services.

(2) Only the technical component of a radiological service or a laboratory service shall be billed on the standardized UB-92 national uniform billing claim form.

(3) All bills for the professional services shall be billed on a CMS 1500 claim form, using the appropriate CPT® procedure code and modifier

(4) A report describing the services provided and the condition of the patient shall be included with the bill.

History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

**PART 10. REIMBURSEMENT
SUBPART A. PRACTITIONER REIMBURSEMENT**

R 418.101001 General rules for practitioner reimbursement.

Rule 1001. (1) A provider that is authorized to practice in the state of Michigan shall receive the maximum allowable payment in accordance with these rules. A provider shall follow the process specified in these rules for resolving differences with a carrier regarding payment for appropriate health care services rendered to an injured worker.

(2) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.

(3) A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.

(4) A carrier shall pay, adjust, or reject a properly submitted bill within 30 days of receipt. The carrier shall notify the provider on a form entitled "Carrier's Explanation of Benefits" in a format specified by the bureau. A copy shall be sent to the injured worker.

(5) A carrier shall not make a payment for any service which is determined inappropriate by the carrier's professional health care review program.

(6) The carrier shall reimburse the provider a 3% late fee if more than 30 calendar days elapse between a carrier's receipt of a properly submitted bill and a carrier's mailing of the payment.

(7) If a procedure code has a maximum fee of "by report," the provider shall be paid usual and customary charge or the reasonable amount, whichever is less. The carrier shall provide an explanation of its determination that the fee is unreasonable or excessive in accordance with these rules.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101002 Conversion factors for medical, surgical, and radiology procedure codes.

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

(2) The conversion factor for medicine, radiology, and surgical procedures shall be \$48.49 for the year 2005 and shall be effective for dates of service on or after the effective date of these rules.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101003 Reimbursement for "by report" and ancillary procedures.

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

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

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

(3) Prescription medication shall be reimbursed at the average wholesale price (AWP) + a \$4.00 dispense fee for each drug, as determined by the Red Book, referenced in R 418.10107(e).

(4) Over-the-counter drugs (OTC's), dispensed by a provider other than a pharmacy, shall be dispensed in 10-day quantities and shall be reimbursed at the average wholesale price, as determined by the Red Book, or \$2.50, whichever is greater.

(5) Durable medical equipment, supplies, including pre-fabricated splints, shall be reimbursed by the carrier at the average wholesale price, plus not more than 50%, or the provider's usual and customary charge, whichever is less.

(6) Orthotic and prosthetic procedures, L0100-L8499, and assigned maximum allowable payments shall be listed in R 418.101504.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101004 Modifier code reimbursement.

Rule 1004. (1) When accompanied by a modifier code, a procedure code shall be considered to have a maximum allowable payment of BR, except as provided for by subrules (2) to (13) of this rule.

(2) When modifier code -25 is added to an evaluation and management procedure code, reimbursement shall only be made when the documentation provided supports the patient's condition required a significant separately identifiable evaluation and management service other than the other service provided or beyond the usual preoperative and postoperative care.

(3) When modifier code -26, professional component, is used with a radiology procedure, the payment shall be determined by multiplying the relative value for the professional component times the radiology conversion factor.

(4) If a surgeon uses modifier code -47 when performing a surgical procedure, then anesthesia services were provided by the surgeon and the maximum allowable payment for the anesthesia portion of the service shall be calculated by multiplying the base unit of the appropriate anesthesia code by \$42.00. No additional payment is allowed for time units.

(5) When modifier code -50 or -51 is used with procedure codes 10000-69999, a doctor of dental surgery, doctor of medicine, doctor of osteopathy, or doctor of podiatry shall be paid the following:

(a) The primary procedure at not more than 100% of the maximum allowable payment or the billed charge, whichever is less.

(b) The secondary procedure and the remaining procedure or procedures at not more than 50% of the maximum allowable payment or the billed charge, whichever is less.

(c) When multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body shall be reimbursed 100% of the maximum allowable payment or billed charge, whichever is less, and the second and remaining surgical procedure or procedures shall be identified by modifier code -51 and shall be reimbursed at 50% of the maximum allowable payment or billed charges, whichever is less.

(d) When modifier -50 or -51 is used with a surgical procedure with a maximum allowable payment of BR, the maximum allowable payment shall be 50% of the provider's usual and customary charge or 50% of the reasonable amount, whichever is less.

(6) When modifier code -TC, technical services, is used to identify the technical component of a radiology procedure, payment shall be made for the technical component only. The maximum allowable payment for the technical portion of the radiology procedure is designated in the manual by -TC.

(7) When modifier -57, initial decision to perform surgery, is added to an evaluation and management procedure code, the modifier -57 shall indicate that a consultant has taken over the case and the consultation code is not part of the global surgical service.

(8) When both surgeons use modifier -62 and the procedure has a maximum allowable payment, the maximum allowable payment for the procedure shall be multiplied by 25%. Each surgeon shall be paid 50% of the maximum allowable payment times 25%, or 62.5 % of the MAP. If the maximum allowable payment for the procedure is BR, then the reasonable amount shall be multiplied by 25% and be divided equally between the surgeons.

(9) When modifier code -80 is used with a procedure, the maximum allowable payment for the procedure shall be 20% of the maximum allowable payment listed in these rules, or the billed charge, whichever is less. If a maximum payment has not been established and the procedure is

BR, then payment shall be 20% of the reasonable payment amount paid for the primary procedure.

(10) When modifier code -81 is used with a procedure code that has a maximum allowable payment, the maximum allowable payment for the procedure shall be 13% of the maximum allowable payment listed in these rules or the billed charge, whichever is less. If modifier code -81 is used with a BR procedure, then the maximum allowable payment for the procedure shall be 13% of the reasonable amount paid for the primary procedure.

(11) When modifier -82 is used and the assistant surgeon is a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine, or a doctor of dental surgery, the maximum level of reimbursement shall be the same as for modifier -80. If the assistant surgeon is a physician's assistant, the maximum level of reimbursement shall be the same as modifier -81. If a person other than a physician or a certified physician's assistant bills using modifier -82, then the charge and payment for the service is reflected in the facility fee.

(12) When modifier -GF is billed with evaluation and management or minor surgical services, the carrier shall reimburse the procedure at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101005 Reimbursement for home health services.

Rule 1005. (1) Home health services are reimbursed "by report", requiring submission of a report with the charges on the UB-92 claim form. The carrier shall reimburse the home health agency according to each "by report" procedure listed on the UB-92, billed with the appropriate HCPCS code in accord with R 418.10909.

(2) Home health services shall be reimbursed by the carrier at either the provider's usual and customary charge as defined by these rules or reasonable amount, whichever is less.

(3) Services listed in "HCPCS, Medicare Level II Codes" as adopted by reference in R 418.10107 as per diem shall be reimbursed per diem or per visit in accord with the description of the code. The per diem visit shall be either at the provider's usual and customary charge or reasonable amount, whichever is less.

(4) When a home health agency bills for supplies on the UB-92, the supplies shall be reimbursed at AWP, average wholesale price plus not more than a 50% markup above average wholesale price.

History: 2002 MR 1, Eff. Jan. 11, 2002.

R 418.101006 Reimbursement for mental health services.

Rule 1006. (1) A carrier shall only reimburse procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, 90862, 90865, 90870, and 90871 when billed by a psychiatrist (an M.D. or D.O).

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

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

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

maximum allowable payment shall be 85% of the reasonable payment, or the practitioner's usual and customary charge, whichever is less:

- (a) -AL limited license psychologist.
- (b) -AJ certified social worker.
- (c) -LC licensed professional counselor.
- (d) -MF licensed marriage and family therapist.

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

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

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000.

R 418.101007 Reimbursement for anesthesia services.

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

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

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

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

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

(a) If the anesthesiologist administers the anesthesia, then the modifier shall be -AA and the maximum payment shall be \$2.80 per minute.

(b) If the anesthesiologist supervises a CRNA, then the modifier shall be -QK and the maximum payment shall be \$1.40 per minute.

(c) If a CRNA supervised by an anesthesiologist administers the anesthesia, then the modifier shall be -QX and the maximum payment shall be \$2.80 per minute.

(d) If a CRNA administers without supervision of the anesthesiologist, then the modifier shall be -QZ and the maximum payment shall be \$2.80 per minute.

History: 2000 MR 6, Eff. May 11, 2000.

PART 10. REIMBURSEMENT
SUBPART B. FACILITY REIMBURSEMENT

R 418.101015 General rules for facility reimbursement.

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

(2) The carrier or its designated agent shall assure that the UB-92 national uniform billing claim form, (D1450), is completed correctly before payment. A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.

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

(4) Submission of a correctly completed UB-92 claim form shall be considered to be a properly submitted bill. The following medical records shall also be attached to the facility charges as applicable:

- (a) Emergency room report.
- (b) The initial evaluations and progress reports every 30 days whenever physical medicine, speech and hearing services are billed by a facility.
- (c) The anesthesia record whenever the facility bills for the services of a CRNA or anesthesiologist.

(5) Additional records not listed in subrule (4) of this rule may be requested by the carrier and shall be reimbursed in accordance with R 418.10118.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101016 Reimbursement for hospital facility services.

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

- (a) Inpatient or observation care.
- (b) Emergency department services.
- (c) Occupational, physical, and speech therapy services.
- (d) Outpatient surgeries.
- (e) Laboratory services and outpatient services not listed on Table 10922.

If a carrier pays a properly submitted bill or unadjusted portion of the bill within 30 days of receipt, then the payment is calculated by multiplying the charges times the hospital's maximum payment ratio times a multiplier of 107%. If a carrier pays the bill after 30 days, then the multiplier shall be 110% allowing for a 3% late fee.

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

(3) If applying the ratio methodology results in an amount greater than the hospital's charge, the carrier shall reimburse the hospital's charge. The only time a carrier shall pay in excess of the

charge is if a properly submitted bill was not paid within 30 days and, in that instance, the carrier shall reimburse the charge plus a 3% late fee.

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

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101017 Reimbursement for outpatient minor medical-surgical procedures performed in outpatient hospital setting when billed on UB-92.

Rule 1017. (1) Reimbursement for services listed on Table 10922 shall be made as follows:

(a) If the service occurs in the first 10 days of care beginning for a work injury, then the hospital shall be reimbursed by the ratio methodology. The ratio methodology shall be used to reimburse the hospital facility for the following services:

- (i) Outpatient surgery.
- (ii) Appropriate emergency room visits.
- (iii) Inpatient hospitalization or 24-hour outpatient observation stays.

(b) If the service occurs after the first 10 days, then the carrier shall reimburse the facility for the technical component of the procedure, or 60% of the maximum allowable payment for those minor medical, surgical and radiology procedures.

(2) This rule shall not apply to services performed in a hospital-owned or hospital-system owned occupational or industrial clinics or departments, as those services shall be considered practitioner services and shall be billed and paid as a practitioner service.

History: 2000 MR 6, Eff. May 11, 2000; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101018 Technical services performed in the hospital.

Rule 1018. (1) If the following services are performed in the outpatient hospital setting, then the hospital shall be reimbursed by the payment ratio methodology and shall not have a professional component billed:

- (a) Casting and strapping procedures performed by hospital technicians.
- (b) Laboratory services.
- (c) Physical, occupational, and speech therapy services.
- (d) Procedures describing EKG tracings only.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.101019 Procedure codes not payable to hospitals.

Rule 1019. The following procedures are practitioner services and shall not be paid to a facility when billed on the UB-92:

53670	93000	93720
93015	93040	

History: 2000 MR 6, Eff. May 11, 2000.

R 418.101022 Facility reimbursement excluding hospital or freestanding surgical outpatient facility.

Rule 1022. (1) When the following licensed facilities provide services to an injured worker and bill the carrier, the billed services shall be considered by report:

- (a) Nursing home.

- (b) County medical care facility.
- (c) Hospice.
- (d) Hospital long-term care unit.
- (e) Intermediate care facility or skilled nursing facility.

(2) A licensed facility in subrule (1) of this rule shall be reimbursed by its usual and customary charge or reasonable amount for the service provided, whichever is less. If a carrier does not reimburse the facility within 30 days of receipt of a properly submitted bill, the carrier shall reimburse the facility an additional 3% late fee.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101023 Reimbursement for a freestanding surgical outpatient facility service.

Rule 1023. (1) Reimbursement for surgical procedures performed in a freestanding surgical outpatient facility shall be determined by using grouper rates as determined by Medicare and published in the Federal Register. The surgical procedures shall be classified into 1 of 9 groupers, numbered 1-9. An allowable rate is assigned to each grouper and the payment is determined by multiplying the grouper rate times a wage index. The rates for the groupers shall be published by the agency in the Health Care Services Manual. The wage index shall be determined by the workers' compensation agency and shall be published in the Health Care Services Manual.

(2) The state of Michigan workers' compensation health care services rules shall adopt the payment system described in subrule 1 of this rule adding 80% to the rate reflecting a payment that is 80% higher than Medicare. The geographical wage-index used to calculate the payment for the surgical procedures shall be 1.0147, representing urban Michigan. The formula for determining the maximum allowable payment (MAP) for a surgical procedure performed in a freestanding surgical outpatient facility shall be as follows: (grouper rate) x (1.8) x (wage-index of 1.0147).

(3) When 2 or more surgical procedures are performed in the same operative session, the facility shall be reimbursed at 100% of the maximum allowable payment or the facility's usual and customary charge, whichever is less, for the procedure classified in the highest payment group. Any other surgical procedures performed during the same session shall be reimbursed at 50% of the maximum allowable payment or 50% of the facility's usual and customary charge, whichever is less. A facility may not un-bundle surgical procedure codes when billing the services.

(4) When an eligible procedure is performed bilaterally, each procedure shall be listed on a separate line of the claim form and shall be identified with LT for left and RT for right. At no time shall modifier 50 be used by the facility to describe bilateral procedures.

(5) When an item is implanted during the surgical procedure and the freestanding surgical outpatient facility bills the implant and includes the copy of the invoice, the implant shall be reimbursed at the cost of the implant plus a percent mark-up as follows:

- (a) Cost of implant: \$1.00-\$500.00 shall receive cost + 50%.
- (b) Cost of implant: \$500.01-\$1000.00 shall receive cost + 30%.
- (c) Cost of implant: \$1000.01 and higher shall receive cost + 25%.

(6) Laboratory services shall be reimbursed by the maximum allowable payment as determined in R 418.101503.

(7) When a radiology procedure is performed intra-operatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be

included with the surgical procedure. Pre-operative and postoperative radiology services may be globally billed.

(8) When the freestanding surgical facility provides durable medical equipment, the items shall be reimbursed in accord with R 418.101003 (5).

History: 2005 MR 4, Eff. Feb 10, 2005

PART 11. HOSPITAL PAYMENT RATIO

R 418.101101 Calculation and revision of payment ratio for Michigan hospitals.

Rule 1101. (1) The workers' compensation agency shall annually calculate and revise, under the provisions of 1969 PA 306, 24.201 et seq. MCL, the payment ratios for all Michigan hospitals. The calculation shall be made using a hospital's most recent fiscal year information that is submitted to the Michigan department of community health, medical services administration, preceding each annual calculation. The information used shall be that reported to the Michigan department of community health, medical services administration, on the hospital's statement of patient revenues and operating expenses, G2 worksheet. The workers' compensation agency shall complete the payment ratio calculation between September 1 and October 1, or the earliest date when the figures are available from Michigan department of community health and shall annually publish the hospital ratio calculations in a separate manual effective for dates of service on or after the effective date of these rules.

(2) The workers' compensation agency shall calculate a hospital's cost-to-charge ratio by dividing each hospital's total operating expenses by total patient revenues as reported on the hospital's statement of patient revenues and operating expenses, G2 worksheet.

History: 2000 MR 6, Eff. May 11, 2000; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101102 Calculation and revision of payment ratio for hospitals outside Michigan.

Rule 1102. The workers' compensation agency shall annually calculate and revise, under the provisions of 1969 PA 306, as amended, being §24.201 et seq. of the MCL, at the same time as calculating Michigan hospitals' payment ratios, a weighted state average payment ratio to be used for hospitals that are located outside the state of Michigan. The payment ratio shall be calculated by dividing the total hospital operating expenses for Michigan by the total hospital patient revenues for Michigan as reported under R 418.1101(1).

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101103 Adjustments to hospital's payment ratio.

Rule 1103. (1) A hospital may apply to the agency for an adjustment of the hospital's maximum payment ratio.

(2) The hospital shall apply for an adjustment on a form and in a manner prescribed by the workers' compensation agency.

(3) If the agency determines that a hospital's ratio of total operating expenses to total patient revenues, as reported on the hospital's statement of patient revenues and operating expenses, G2 worksheet, for a hospital's most recent fiscal year is higher than the payment ratio calculated according to R 418.1101, so that the amount of underpayment is more than \$100,000.00 or is equal to or greater than 2/10 of 1% of the hospital's operating expenses for the year, then the agency shall revise the payment ratio and shall notify the hospital and all carriers of the revised payment ratio within 45 days after the receipt of a properly submitted request for an adjustment.

(4) If a hospital's request for an adjustment to the hospital's payment ratio is denied by the workers' compensation agency, then a hospital may request reconsideration and appeal of the agency's action regarding the hospital's request for adjustment of its payment ratio.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101104 Request for adjustment to hospital's maximum payment ratio; agency's response.

Rule 1104. (1) Within 60 days of the agency's receipt of a hospital's request for adjustment to the hospital's maximum payment ratio, the workers' compensation agency shall notify the hospital of the action on the adjustment request and shall notify the hospital of the hospital's right to provide additional information to request reconsideration of the agency's action.

(2) The workers' compensation agency shall also furnish the hospital with an appeal form. The appeal form shall include an explanation of the appeal process.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101105 Agency's action on request for adjustment of maximum payment ratio; hospital's appeal.

Rule 1105. (1) If a hospital is in disagreement with the action taken by the workers' compensation agency on its request for adjustment of the hospital's maximum payment ratio, then a hospital may, within 30 days of receipt of the agency's action on the hospital's request for adjustment to its maximum payment ratio, deliver or mail an appeal of the agency's action to the agency. The appeal shall include a detailed statement of the reasons for disagreement and shall request reconsideration of the agency's action on the hospital's request for adjustment.

(2) The workers' compensation agency shall hold a hearing within 30 days of the receipt of a hospital's appeal under section 847 of the act.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

PART 12. CARRIER'S REVIEW OF HEALTH CARE REVIEW

R 418.101201 Carrier's health care review program.

Rule 1201. (1) The carrier shall have both a technical health care review program and a professional health care review program.

(2) Health care review shall be conducted in a reasonable manner on bills submitted by a provider for health care services furnished because of a covered injury or illness arising out of and in the course of employment.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.101203 Carrier's technical health care review program.

Rule 1203. Under the technical health care review program, the carrier shall do all of the following:

(a) Determine the accuracy of the procedure coding. If the carrier determines, based upon review of the bill and any related material which describes the procedure performed, that the procedure is incorrectly or incompletely coded, then the carrier may re-code the procedure, but shall notify the provider of the reasons for the recoding within 30 days of receipt of the bill under part 13 of these rules.

(b) Determine that the amount billed for a procedure does not exceed the maximum allowable payment established by these rules. If the amount billed for a procedure exceeds the maximum allowable payment, then the carrier shall reimburse the maximum allowable payment for that procedure.

(c) Identify those bills and case records which, under R 418.101205, shall be subject to professional health care review.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.101204 Carrier's professional health care review program.

Rule 1204. (1) A carrier may have another entity perform professional health care review activities on its behalf.

(2) The workers' compensation agency shall certify a carrier's professional health care review program pursuant to R 418.101206.

(3) The carrier shall submit a completed form entitled "Application for Certification of the Carrier's Professional Health Care Review Program" to the agency. If the carrier is a self-insured employer or self-insured group fund, then the service company information shall be included on the form in addition to the carrier and review company information. In addition to the completed form, the carrier shall submit all of the following:

(a) The methodology used to perform professional review.

(b) A listing of the licensed, registered, or certified health care professionals reviewing the health care bills or establishing guidelines for technical review. In addition, the proof of current licensure and qualifications for the health care professionals shall be included with the completed application.

(c) A list of the carrier's peer review staff, including specialty.

(4) The workers' compensation carrier as defined by these rules maintains full responsibility for compliance with these rules.

(5) The carrier shall determine medical appropriateness for the services provided in connection with the treatment of a covered injury or illness, using published, appropriate standard medical practices and resource documents. Utilization review shall be performed using 1 or both of the following approaches:

(a) Review by licensed, registered, or certified health care professionals.

(b) The application by others of criteria developed by licensed, registered, or certified health care professionals.

(6) The licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.

(7) The licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

(8) When peer review is utilized, a health care professional of the same specialty type as the provider of the medical service shall perform the review.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101205 Scope of professional health care review.

Rule 1205. (1) The carrier, or its review company, shall review case records and health-service bills, or both, under the professional health care review program as follows:

(a) A case where health care service payments, excluding inpatient hospital care, exceed \$20,000.00.

(b) A case involving inpatient hospital care.

(2) The carrier or other entity may at any time review any case record or bill which the carrier or the other entity believes may involve inappropriate, insufficient, or excessive care.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101206 Certification of professional health care review program.

Rule 1206. (1) The workers' compensation agency shall certify the carrier's professional health care review program.

(2) A carrier, or the reviewing entity on behalf of the carrier, shall apply to the agency for certification of a carrier's professional health care review program in the manner prescribed by the workers' compensation agency. The carrier shall submit a copy of "The Carriers Explanation of Benefits" form utilized to notify providers of payment decisions.

(3) A carrier shall receive certification if the carrier or the carrier's review company provides to the agency a description of its professional health care review program and includes all of the information specified in R 418.101204. The workers' compensation agency shall send a copy of the certification of the carrier's review program to the carrier, and to the service company and review company when appropriate.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101207 Types of certification.

Rule 1207. (1) Certification shall be either unconditional or conditional.

(2) The workers' compensation agency shall issue unconditional certification for a period of 3 years.

(3) The agency may issue conditional certification if it is determined that the carrier or other entity does not fully satisfy the criteria in R 418.101206(3). If the carrier or other entity agrees to undertake corrective action, then conditional certification shall be granted by the agency for a maximum period of 1 year.

(a) If the workers' compensation agency receives multiple written complaints regarding a carrier, or the carrier's review process, and the agency determines the complaints are valid, or that the carrier has not processed payment for medical services in accord with these rules, then the agency may issue conditional certification.

(4) The workers' compensation agency may at any time modify an unconditional certification to a conditional certification if the agency determines that the carrier or other entity fails to satisfy the criteria set forth in R 418.101206(3).

(5) The carrier shall have the right to appeal the certification decisions under the procedures in these rules.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101208 Renewal of certification.

Rule 1208. (1) A carrier or other entity shall apply to the workers' compensation agency for renewal of certification in the manner prescribed by the agency, submitting the application 6 months prior to the expiration date on the certification.

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

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101209 Carrier's request for reconsideration of professional review certification.

Rule 1209. (1) Within 30 days of the agency's denial of a carrier's request for professional review program certification, the agency shall notify the carrier of the reasons for denial of the certification and shall notify the carrier of its right to request reconsideration of the denial providing additional information.

(2) A carrier shall notify the agency, within 30 days of receipt of the professional review program certification denial, of its disagreement with the action of the agency. The carrier's notice to the agency of disagreement with the agency's denial shall include a detailed statement of the reasons for the disagreement and shall request reconsideration.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101210 Carrier's request for reconsideration of professional review program certification; response.

Rule 1210. (1) Within 30 days of receipt of a carrier's request for reconsideration of professional review program certification, the workers' compensation agency shall notify the carrier of the actions taken and shall furnish a detailed statement of the reasons for the action taken.

(2) The agency shall furnish the carrier with an appeal form. The appeal form shall include an explanation of the appeal process.

(3) If a carrier is in disagreement with the action taken by the agency on its request for reconsideration, then a carrier shall deliver or mail its appeal to the agency.

(4) The workers' compensation agency shall hold a hearing within 30 days of the receipt of a carrier's appeal of the agency's decision regarding certification of the carrier's professional review program under section 847 of the act.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

**PART 13. PROCESS FOR RESOLVING DIFFERENCES
BETWEEN CARRIER AND PROVIDER REGARDING BILL**

R 418.101301 Carrier's adjustment or rejection of properly submitted bill.

Rule 1301. (1) If a carrier adjusts or rejects a bill or a portion of the bill, then the carrier shall notify the provider within 30 days of the receipt of the bill of the reasons for adjusting or rejecting the bill or a portion of the bill and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action. The carrier shall set forth the specific reasons for adjusting or rejecting a bill or a portion of the bill and request specific information on a form, "Carrier's Explanation of Benefits," prepared by the agency pursuant to the reimbursement section of these rules.

(2) If the provider sends a properly submitted bill to a carrier and the carrier does not respond within 30 days, and if a provider sends a second properly submitted bill and does not receive a response within 60 days from the date the provider supplied the first properly submitted bill, then the provider may file an application with the agency for mediation or hearing. The provider shall

send a completed form entitled “Application for Mediation and Hearing” to the agency and shall send a copy of this form to the carrier.

(3) The carrier shall notify the employee and the provider that the rules prohibit a provider from billing an employee for any amount for health care services provided for the treatment of a covered work-related injury or illness if that amount is disputed by the carrier under its utilization review program or if the amount is more than the maximum allowable payment established by these rules. The carrier shall request the employee to notify the carrier if the provider bills the employee.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101302 Provider’s request for reconsideration of properly submitted bill.

Rule 1302. A provider may request reconsideration of its adjusted or rejected properly submitted bill by a carrier within 60 days of receipt of a notice of an adjusted or rejected bill or a portion of the bill. The provider’s request to the carrier for reconsideration of the adjusted or rejected bill shall include a detailed statement of the reasons for disagreement with the carrier’s adjustment or rejection of a bill or a portion of the bill.

History: 2000 MR 6, Eff. May 11, 2000.

R 418.101303 Provider’s request for reconsideration of bill; carrier’s response to provider’s right to appeal.

Rule 1303. (1) Within 30 days of receipt of a provider’s request for reconsideration, the carrier shall notify the provider of the actions taken and provide a detailed statement of the reasons. The carrier’s notification shall include an explanation of the appeal process provided under these rules, including the fact that any requested administrative appeal hearing shall be conducted by a magistrate of the department of labor & economic growth.

(2) If a provider disagrees with the action taken by the carrier on the provider’s request for reconsideration, then a provider may file an application for mediation or hearing with the department of labor & economic growth. A provider shall send its application for mediation or hearing to the agency within 30 days from the date of receipt of a carrier’s denial of the provider’s request for reconsideration. The provider shall send a copy of the application to the carrier.

(3) If, within 60 days of the provider’s request for reconsideration, the provider does not receive payment for the adjusted or rejected bill or a portion of the bill, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may apply for mediation or hearing. The provider shall send the application for mediation or hearing to the agency and shall send a copy to the carrier.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101304 Disputes.

Rule 1304. (1) If a carrier adjusts or rejects a bill or a portion of a bill under these rules, then a notice given under R 418.101301(1) creates an ongoing dispute for the purpose of section 801 of the act. The time for making payment of a bill under section 801 of the act shall not run unless the bill is properly submitted according to applicable rules and statutes.

(2) Any dispute that concerns any of the following shall be resolved as if an application for mediation or hearing was filed under section 847 of the act:

- (a) The medical appropriateness of health care or a health care service.
- (b) Utilization of health care or a health care service.

(c) The need for health care or a health care service.

(d) Any dispute over the cost of health care or a health care service.

(3) If the dispute results in the denial of medical treatment for a worker, or if there is a petition by an employer to stop the employer's liability for medical benefits previously ordered, including proceedings under subrule (6) of this rule, then the dispute shall receive the same expedited treatment accorded to 60-day cases under section 205 of the act, except that the agency may refer the matter to mediation under section 223 of the act.

(4) A dispute under this rule may be submitted to arbitration under section 864 of the act.

(5) A dispute under this rule may be handled as a small claim under section 841(2) to (10) of the act if it meets the requirements of that section.

(6) If a carrier is required by the terms of an award to provide medical benefits, then the carrier shall continue to provide those benefits until there is a different order by any of the following entities:

(a) A magistrate.

(b) The appellate commission.

(c) The court of appeals.

(d) The supreme court.

This subrule shall not preclude the use of the maximum allowable payments provided by these rules for the payment of bills by carriers. If a carrier files an application to stop or limit its liability under this subrule, the carrier shall receive the expedited treatment provided for under subrule (3) of this rule.

(7) If the agency believes that a provider is not in compliance with these rules, then the agency may file an application for mediation or hearing under this rule.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101305 Resolution of disputes.

Rule 1305. (1) If a carrier adjusts a fee or rejects a bill under these rules, then a notice given pursuant to R 418.101301 creates a continuing dispute for the purpose of section 801 of the act. The time for making payment of a bill under section 801 of the act shall not run unless the bill is properly submitted according to applicable rules and statutes.

(2) A magistrate, as provided under sections 315 and 847 of the act and R 408.34 and R 408.35, shall resolve any dispute that concerns any of the following:

(a) The medical appropriateness of health care or a health care service.

(b) Utilization of health care or a health care service.

(c) The need for health care or a health care service.

(d) Any dispute over the cost of health care or a health care service.

(3) The agency may participate in any hearings that concern disputes when there is an issue that affects the provisions of these rules regarding maximum fees, medical appropriateness, or utilization of health care or health care services.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

PART 14. DATA ACQUISITION

R 418.101401 Annual medical payment report.

Rule 1401. (1) Payments for medical services received by injured workers shall be reported to the workers' compensation agency on a form prescribed by the agency entitled "Annual

Medical Payment Report.” The agency shall provide instruction to the carriers and service companies regarding completion of the form. The annual medical payment report shall cover the periods January 1 through December 31 and shall include all of the following information:

(a) The carrier’s total number of worker’s compensation cases and the total medical payments for health care services for those cases in the reporting period.

(b) Medical only cases, defined as those cases where no indemnity was paid, and the total medical payments made by the carrier for those cases.

(c) Wage loss cases, defined as those cases in which wage loss or indemnity was paid, and the total medical payments made by the carrier for those cases. For the purposes of this annual medical payment report, once wage loss benefits are paid, then the case shall always be reported as wage loss.

(2) The annual medical payment report shall be due in the agency by February 28 of each year. The report shall not include travel expenses, payments for independent medical examinations, vocational rehabilitation, or rehabilitation case management expenses.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101402 Access to workers’ compensation case records.

Rule 1402. (1) The workers’ compensation agency shall have access to necessary workers’ compensation health care records, medical bills, and other information concerning health care or health service from workers’ compensation carriers or providers.

(2) The agency may review the records and medical bills of any provider determined by a carrier to not be in compliance with the rules or to be requiring unjustified treatment, hospitalization, or office visits. If a carrier requests the agency to perform an on-site review of specific records and medical bills of a provider, then the agency shall arrange a mutually acceptable visit date with the provider, by telephone or in writing, at least 15 working days before the visit. The agency shall confirm the date of the visit in writing not less than 10 working days in advance. The agency shall, by that time, identify for the provider the records, which the agency wishes to review. The records shall remain at the provider’s place of business.

(3) The workers’ compensation agency shall ensure confidentiality of the individual case records regarding health care services provided to any individual.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101404 Access to carrier data for payment of medical claims.

Rule 1404. (1) The workers’ compensation agency shall have access to payment data from the carrier in the form of the carrier’s explanation of benefits and medical bills for the purposes of data analysis.

(2) A carrier shall be notified by the agency when information is to be submitted not less than 60 days before the date required.

(3) The agency shall ensure confidentiality of the billing records provided by the selected carriers.

History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 4, Eff. Feb 10, 2005.

PART 15. PROCEDURE CODE AND REIMBURSEMENT TABLES

R 418.101501 Tables for health care services and procedures.

Rule 1501. (1) Procedures that do not have relative values assigned are referenced in part 15

of these rules and have assigned fees developed by the workers' compensation agency through rule promulgation and shall be published as part of these rules.

(2) The agency shall publish separate from these rules a manual containing all of the following:

- (a) Procedure codes and relative value units for the medical, surgical, and radiology services.
- (b) Reference to the ancillary services identified in Medicare's Level II codes as adopted by reference in R 418.10107.
- (c) Maximum payment ratios for hospitals.
- (d) A copy of the billing forms and instructions for completion.

History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101502 Miscellaneous medical and surgical procedures.

Rule 1502. The medical and surgical procedures without assigned relative values or specific payment methodologies are listed in the following table:

99000	Handling or conveyance of specimen	\$5.00
99050	After hour office service Monday-Friday (R 418.10202).....	\$5.00
99052	Services between 10:00pm and 8:00am	\$5.00
99054	Weekend, holiday after hour office service	\$12.00
99199	Carrier arranged missed appointment. (R 418.10111).....	BR
99199-32	Carrier or requested report, per page (R 418.10114).....	\$25.00
WC700	Prescription drug dispense fee (R 418.10912(4)	\$4.00
99455-32	Carrier requested visit for job evaluation (R 418.10404)	\$70.00
RN001-32	Rehabilitation or case manager visit (R 418.10121).....	\$25.00

History: 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101503 Laboratory procedure codes and maximum allowable payments.

Rule 1503. (1) The workers' compensation agency shall determine the maximum allowable payment for the laboratory procedure codes,80048-89356 published in "Physicians' Current Procedural Terminology (CPT®)as adopted by reference in R 418.10107. The rate shall be determined by multiplying the Medicare rate established for the state of Michigan by 110%.

(2) The pathology procedure codes found in the 80000 series of procedure codes listed in CPT® as adopted by reference in R 418.10107 have assigned relative values and shall be published by the agency in a separate manual.

(3) The maximum allowable payments for the laboratory and pathology procedures shall be published the Health Care Services Manual separate from these rules.

History: 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 4, Eff. Feb 10, 2005.

R 418.101504 Orthotic and prosthetic codes and maximum allowable payments.

Rule 1504. The orthotic and prosthetic codes, the L-code procedures that have set fees are listed in this rule. All other L-code procedures shall be listed in Medicare's National Level II, HCPCS as adopted by reference in R 418.10107 and shall be reimbursed as a by report procedure. The maximum allowable fees for the L-code procedures are listed in the table in this rule:

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L0120	cervical, flexible, nonadjustable (foam collar)	\$17.29
L0130	cervical, flexible, thermoplastic collar, molded to patient	\$117.02
L0140	cervical, semi-rigid, adjustable (plastic collar)	\$42.00
L0150	cervical, semi-rigid, adjustable molded chin cup	\$74.60
L0160	cervical, semi-rigid, wire frame occipital/mandibular support	\$119.82
L0170	cervical collar, molded to patient model	\$796.31
L0172	cervical collar, semi-rigid, thermoplastic foam, two-piece	\$110.00
L0174	cervical collar, semi-rigid, thermoplastic foam, two-piece with	\$194.07
L0180	cervical, multiple post collar, occipital/mandibular supports,	\$314.44
L0190	cervical, multiple post collar, occipital/mandibular supports,	\$407.89
L0200	cervical, multiple post collar, occipital/mandibular supports,	\$430.12
L0210	thoracic rib belt, custom fitted	\$28.85
L0220	thoracic rib belt, custom fabricated	\$90.00
L0500	lso, flexible (lumbo-sacral surgical support), custom fitted	\$99.00
L0510	lso, flexible (lumbo-sacral surgical support), custom	\$214.00
L0515	lso, flexible (lumbo-sacral surgical support), elastic type, w/	\$176.00
L0520	lso, anterior-posterior-lateral control (knight, wilcox types),	\$358.03
L0530	lso, anterior-posterior control (macausland type), with apron	\$359.95
L0540	lso, lumbar flexion (williams flexion type)	\$387.68
L0550	lso, anterior-posterior-lateral control, molded to patient	\$1,273.00
L0560	lso, ant.-posterior-lateral control, molded to patient model,	\$1,590.56
L0565	lso, anterior-posterior-lateral control, custom fitted	\$902.84
L0600	sacroiliac, flexible (sacroiliac surgical support), custom	\$60.09
L0610	sacroiliac, flexible (sacroiliac surgical support), custom	\$224.46
L0620	sacroiliac, semi-rigid, (goldthwaite, osgood types), with apron	\$367.86
L0700	ctlso, ant.-posterior-lateral control, molded to patient model,	\$1,779.93
L0710	ctlso, anterior-posterior-lateral-control, molded to patient	\$1,882.90
L0810	halo procedure, cervical halo incorporated into jacket vest	\$2,371.87
L0820	halo procedure, cervical halo incorporated into plaster body	\$1,876.79
L0830	halo procedure, cervical halo incorporated into milwaukee type	\$2,829.65
L0860	addition to halo procedure, magnetic resonance image compatible	\$960.00
L0960	torso support, postsurgical support, pads for postsurgical	\$60.01
L0970	tlso, corset front	\$99.30
L0972	lso, corset front	\$89.42
L0974	tlso, full corset	\$155.56
L0976	lso, full corset	\$138.95
L0978	axillary crutch extension	\$167.24
L0980	peroneal straps, pair	\$15.17
L0982	stocking supporter grips, set of four (4)	\$14.15
L0984	protective body sock, each	\$47.18

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes) A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	Map
L1000	ctlso, inclusive of furnishing initial orthosis, including	\$1,763.98
L1010	addition to ctlso or scoliosis orthosis, axilla sling	\$58.31
L1020	addition to ctlso or scoliosis orthosis, kyphosis pad	\$75.11
L1025	addition to ctlso or scoliosis orthosis, kyphosis pad, floating	\$108.35
L1030	addition to ctlso or scoliosis orthosis, lumbar bolster pad	\$55.27
L1040	addition to ctlso or scoliosis orthosis, lumbar or lumbar rib	\$67.79
L1050	addition to ctlso or scoliosis orthosis, sternal pad	\$72.34
L1060	addition to ctlso or scoliosis orthosis, thoracic pad	\$83.09
L1070	addition to ctlso or scoliosis orthosis, trapezius sling	\$78.18
L1080	addition to ctlso or scoliosis orthosis, outrigger	\$48.08
L1085	addition to ctlso or scoliosis orthosis, outrigger, bilateral	\$133.74
L1090	addition to ctlso or scoliosis orthosis, lumbar sling	\$79.64
L1100	addition to ctlso or scoliosis orthosis, ring flange, plastic	\$138.17
L1110	addition to ctlso or scoliosis orthosis, ring flange, plastic	\$221.90
L1120	addition to ctlso, scoliosis orthosis, cover for upright, each	\$34.51
L1200	tlso, inclusive of furnishing initial orthosis only	\$1,424.25
L1210	addition to tlso (low profile), lateral thoracic extension	\$227.34
L1220	addition to tlso (low profile), anterior thoracic extension	\$192.48
L1230	addition to tlso (low profile), milwaukee type superstructure	\$493.91
L1240	addition to tlso (low profile), lumbar derotation pad	\$67.46
L1250	addition to tlso (low profile), anterior asis pad	\$62.77
L1260	addition to tlso (low profile), anterior thoracic derotation	\$65.74
L1270	addition to tlso (low profile), abdominal pad	\$67.32
L1280	addition to tlso (low profile), rib gusset (elastic), each	\$74.95
L1290	addition to tlso (low profile), lateral trochanteric pad	\$68.29
L1300	other scoliosis procedure, body jacket molded to patient model	\$1,451.36
L1310	other scoliosis procedure, postoperative body jacket	\$1,493.46
L1499	spinal orthosis, not otherwise classisfied	BR
L1500	thkao, mobility frame (newington, parapodium types)	\$1,650.36
L1510	thkao, standing frame	\$828.93
L1520	thkao, swivel walker	\$1,486.64
L1685	ho, abduction control of hip joint, postop. Hip abduction	\$1,033.49
L1686	ho, abduction control of hip joint, postop. Hip abduction type,	\$653.04
L1800	ko, elastic with stays, prefabricated, includes fitting and	\$43.34
L1810	ko, elastic with joints, prefabricated, includes fitting and	\$81.00
L1815	ko, elastic or other elastic type material with condylar pad(s)	\$63.13
L1820	ko, elastic or other elastic type material with condylar pads	\$103.00
L1825	ko, elastic knee cap, prefabricated	\$35.83
L1830	ko, immobilizer, canvas longitudinal, prefabricated	\$57.01
L1832	ko, adjustable knee joints, positional orthosis, rigid support,	\$480.05

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
		Map
L1834	ko, without knee joint, rigid, custom fabricated	\$674.46
L1840	ko, derotation, medial-lateral, anterior cruciate ligament,	\$798.89
L1844	ko, single upright, thigh and calf, with adjustable flexion and	\$734.88
L1845	ko, double upright, thigh and calf, with adjustable flexion and	\$583.78
L1846	ko, double upright, thigh and calf, with adjustable flexion and	\$985.10
L1850	ko, swedish type, prefabricated	\$187.57
L1855	ko, molded plastic, thigh and calf sections, with double	\$954.77
L1858	ko, molded plastic, polycentric knee joints, pneumatic knee	\$1,221.93
L1860	ko, modification of supracondylar prosthetic socket, custom	\$1,383.48
L1870	ko, double upright, thigh and calf lacers, with knee joints,	\$909.28
L1880	ko, double upright, nonmolded thigh and calf cuffs/lacers with	\$550.82
L1900	afo, spring wire, dorsiflexion assist calf band, custom	\$234.40
L1902	afo, ankle gauntlet, prefabricated, includes fitting and	\$52.02
L1904	afo, molded ankle gauntlet, custom fabricated	\$333.00
L1906	afo, multi-ligamentous ankle support, prefabricated	\$86.17
L1910	afo, posterior, single bar, clasp attachment to shoe counter,	\$174.27
L1920	afo, single upright with static or adjustable stop (phelps or	\$286.29
L1930	afo, plastic, prefabricated	\$175.57
L1940	afo, plastic, custom fabricated	\$429.68
L1945	afo, molded to patient model, plastic, rigid anterior tibial	\$1,145.70
L1950	afo, spiral, (irm type), plastic, custom fabricated	\$647.18
L1960	afo, posterior solid ankle, plastic, custom fabricated	\$530.36
L1970	afo, plastic, with ankle joint, custom fabricated	\$618.24
L1980	afo, single upright free plantar dorsiflexion, solid stirrup,	\$318.88
L1990	afo, double upright free plantar dorsiflexion, solid stirrup,	\$459.09
L2000	kafo, single upright, free knee, free ankle, solid stirrup,	\$881.27
L2010	kafo, single upright, free ankle, solid stirrup, thigh and calf	\$803.35
L2020	kafo, double upright, free knee, free ankle, solid stirrup,	\$1,132.33
L2030	kafo, double upright, free ankle, solid stirrup, thigh and calf	\$880.19
L2036	kafo, full plastic, double upright, free knee, custom	\$2,022.35
L2037	kafo, full plastic, single upright, free knee, custom	\$1,447.16
L2038	kafo, full plastic, without knee joint, multiaxis ankle, custom	\$1,024.83
L2040	hkafo, torsion control, bilateral rotation straps, pelvic	\$154.26
L2050	hkafo, torsion control, bilateral torsion cables, hip joint,	\$413.88
L2060	hkafo, torsion control, bilateral torsion cables, ball bearing	\$504.44
L2070	hkafo, torsion control, unilateral rotation straps, pelvic	\$116.84
L2080	hkafo, torsion control, unilateral torsion cable, hip joint,	\$312.50
L2090	hkafo, torsion control, unilateral torsion cable, ball bearing	\$380.99
L2102	afo, fracture orthosis, tibial fracture cast orthosis, plaster	\$521.09
L2104	afo, fracture orthosis, tibial fracture cast orthosis,	\$619.81

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L2106	afo, fracture orthosis, tibial fracture cast orthosis,	\$747.33
L2108	afo, fracture orthosis, tibial fracture cast orthosis, custom	\$1,170.03
L2112	afo, fracture orthosis, tibial fracture orthosis, soft,	\$304.03
L2114	afo, fracture orthosis, tibial fracture orthosis, semi-rigid,	\$440.38
L2116	afo, fracture orthosis, tibial fracture orthosis, rigid,	\$537.16
L2122	kafo, fracture orthosis, femoral fracture cast orthosis,	\$891.10
L2124	kafo, fracture orthosis, femoral fracture cast orthosis,	\$992.94
L2126	kafo, fracture orthosis, femoral fracture cast orthosis,	\$1,356.79
L2128	kafo, fracture orthosis, femoral fracture cast orthosis, custom	\$1,498.50
L2132	kafo, fracture orthosis, femoral fracture cast orthosis, soft,	\$525.66
L2134	kafo, fracture orthosis, femoral fracture cast orthosis, semi-	\$803.12
L2136	kafo, fracture orthosis, femoral fracture cast orthosis, rigid	\$878.87
L2180	addition to lower extremity fracture orthosis, plastic shoe	\$101.75
L2182	addition to lower extremity fracture orthosis, drop lock knee	\$79.63
L2184	addition to lower extremity fracture orthosis, limited motion	\$107.63
L2186	add. To lower extremity fracture orthosis, adjustable motion	\$130.80
L2188	addition to lower extremity fracture orthosis, quadrilateral	\$260.22
L2190	addition to lower extremity fracture orthosis, waist belt	\$59.45
L2192	addition to lower extremity fracture orthosis, hip joint,	\$309.80
L2200	addition to lower extremity, limited ankle motion, each joint	\$41.30
L2210	addition to lower extremity, dorsiflexion assist (plantar	\$58.40
L2220	add. To lower extremity, dorsiflexion and plantar flexion	\$71.16
L2230	addition to lower extremity, split flat caliper stirrups and	\$66.67
L2240	addition to lower extremity, round caliper and plate attachment	\$72.66
L2250	add. To lower extremity, foot plate, molded to patient model,	\$308.74
L2260	addition to lower extremity, reinforced solid stirrup (scott-	\$174.17
L2265	addition to lower extremity, long tongue stirrup	\$102.31
L2270	addition to lower extremity, varus/valgus correction ("t")	\$46.67
L2275	add. To lower extremity, varus/valgus correction, plastic	\$103.91
L2280	addition to lower extremity, molded inner boot	\$393.43
L2300	addition to lower extremity, abduction bar (bilateral hip	\$233.93
L2310	addition to lower extremity, abduction bar, straight	\$106.88
L2320	addition to lower extremity, nonmolded lacer	\$178.76
L2330	addition to lower extremity, lacer molded to patient model	\$341.16
L2335	addition to lower extremity, anterior swing band	\$197.38
L2340	addition to lower extremity, pre-tibial shell, molded to	\$388.32
L2350	add. To lower extremity, prosthetic type, (bk) socket, molded	\$774.19
L2360	addition to lower extremity, extended steel shank	\$44.96
L2370	addition to lower extremity, patten bottom	\$223.04
L2375	addition to lower extremity, torsion control, ankle joint and	\$99.17

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L2380	addition to lower extremity, torsion control, straight knee	\$106.97
L2385	addition to lower extremity, straight knee joint, heavy duty,	\$116.38
L2390	addition to lower extremity, offset knee joint, each joint	\$95.11
L2395	addition to lower extremity, offset knee joint, heavy duty,	\$101.95
L2397	addition to lower extremity orthosis, suspension sleeve	\$87.81
L2405	addition to knee joint, drop lock, each joint	\$44.22
L2415	addition to knee joint, cam lock (swiss, french, bail types),	\$159.56
L2425	addition to knee joint, disc or dial lock for adjustable knee	\$158.17
L2435	addition to knee joint, polycentric joint, each joint	\$143.80
L2492	addition to knee joint, lift loop for drop lock ring	\$88.60
L2500	add. To lower extremity, thigh/weight bearing, gluteal/ischial	\$274.10
L2510	addition to lower extremity, thigh/weight bearing, quadri-	\$631.12
L2520	add. To lower extremity, thigh/weight bearing, quadri-lateral	\$374.57
L2525	addition to lower extremity, thigh/weight bearing, ischial	\$873.78
L2526	addition to lower extremity, thigh/weight bearing, ischial	\$595.12
L2530	addition to lower extremity, thigh/weight bearing, lacer,	\$204.14
L2540	addition to lower extremity, thigh/weight bearing, lacer,	\$367.33
L2550	addition to lower extremity, thigh/weight bearing, high roll	\$249.53
L2570	addition to lower extremity, pelvic control, hip joint, clevis	\$413.84
L2580	addition to lower extremity, pelvic control, pelvic sling	\$403.24
L2600	addition to lower extremity, pelvic control, hip joint, clevis	\$178.44
L2610	addition to lower extremity, pelvic control, hip joint, clevis,	\$211.00
L2620	addition to lower extremity, pelvic control, hip joint, heavy-	\$232.31
L2622	addition to lower extremity, pelvic control, hip joint,	\$266.44
L2624	addition to lower extremity, pelvic control, hip joint,	\$287.71
L2627	addition to lower extremity, pelvic control, plastic, molded to	\$1,489.46
L2628	addition to lower extremity, pelvic control, metal frame,	\$1,455.67
L2630	addition to lower extremity, pelvic control, band and belt,	\$215.15
L2640	addition to lower extremity, pelvic control, band and belt,	\$291.98
L2650	addition to lower extremity, pelvic and thoracic control,	\$104.27
L2660	addition to lower extremity, thoracic control, thoracic band	\$161.94
L2670	addition to lower extremity, thoracic control, paraspinal	\$148.21
L2680	addition to lower extremity, thoracic control, lateral support	\$135.96
L2750	addition to lower extremity orthosis, plating chrome or nickel,	\$72.62
L2760	addition to lower extremity orthosis, extension, per extension,	\$52.79
L2770	addition to lower extremity orthosis, any material, per bar or	\$53.64
L2780	addition to lower extremity orthosis, non-corrosive finish, per	\$58.80
L2785	addition to lower extremity orthosis, drop lock retainer, each	\$27.54
L2795	addition to lower extremity orthosis, knee control, full	\$57.13
L2800	addition to lower extremity orthosis, knee control, kneecap,	\$92.00

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes) A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	Map
L2810	addition to lower extremity orthosis, knee control, condylar	\$67.86
L2820	addition to lower extremity orthosis, soft interface for molded	\$75.46
L2830	addition to lower extremity orthosis, soft interface for molded	\$81.62
L2840	addition to lower extremity orthosis, tibial length sock,	\$30.06
L2850	addition to lower extremity orthosis, femoral length sock,	\$42.15
L2999	unlisted procedures for lower extremity orthoses	BR
L3000	foot insert, removable, molded to patient model, "ucb" type,	\$170.00
L3001	foot insert, removable, molded to patient model, spenco, each	BR
L3002	foot insert, removable, molded to patient model, plastazote or	\$99.00
L3003	foot insert, removable, molded to patient model, silicone gel,	\$99.00
L3010	foot insert, removable, molded to patient model, longitudinal	\$135.00
L3020	foot insert, removable, molded to patient model,	\$99.00
L3030	foot insert, removable, formed to patient foot, each	BR
L3040	foot, arch support, removable, premolded, longitudinal, each	BR
L3050	foot, arch support, removable, premolded, metatarsal, each	BR
L3060	foot, arch support, removable, premolded,	BR
L3070	foot, arch support, nonremovable, attached to shoe,	BR
L3080	foot, arch support, nonremovable, attached to shoe, metatarsal,	BR
L3090	foot, arch support, nonremovable, attached to shoe, longitudin	BR
L3100	hallus-valgus night dynamic splint	BR
L3150	foot, abduction rotation bar, without shoes	BR
L3215	orthopedic footwear, woman's shoes, oxford	\$94.18
L3216	orthopedic footwear, woman's shoes, depth inlay	\$108.00
L3217	orthopedic footwear, woman's shoes, hightop, depth inlay	\$127.00
L3219	orthopedic footwear, man's shoes, oxford	\$102.87
L3221	orthopedic footwear, man's shoes, depth inlay	\$120.00
L3222	orthopedic footwear, man's shoes, hightop, depth inlay	\$150.00
L3230	orthopedic footwear, custom shoes, depth inlay	\$425.00
L3250	orthopedic footwear, custom molded shoe, removable inner mold,	\$381.00
L3251	foot, shoe molded to patient model, silicone shoe, each	\$450.00
L3252	foot, shoe molded to patient model, plastazote (or similar),	\$300.00
L3253	foot, molded shoe plastazote (or similar), custom fitted, each	\$90.00
L3254	nonstandard size or width	\$38.00
L3257	orthopedic footwear, additional charge for split size	\$180.00
L3260	ambulatory surgical boot, each	\$60.00
L3265	plastazote sandal, each	\$35.00
L3300	lift, elevation, heel, tapered to metatarsals, per inch	\$42.00
L3310	lift, elevation, heel and sole, neoprene, per inch	\$40.00
L3320	lift, elevation, heel and sole, cork, per inch	BR
L3330	lift, elevation, metal extension (skate)	\$275.00

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L3332	lift, elevation, inside shoe, tapered, up to one-half inch	\$18.00
L3334	lift, elevation, heel, per inch	\$25.00
L3340	heel wedge, sach	\$70.00
L3350	heel wedge	\$13.00
L3360	sole wedge, outside sole	\$15.00
L3370	sole wedge, between sole	\$22.00
L3380	clubfoot wedge	\$32.00
L3390	outflare wedge	\$15.00
L3400	metatarsal bar wedge, rocker	\$56.00
L3410	metatarsal bar wedge, between sole	\$64.00
L3420	full sole and heel wedge, between sole	\$32.00
L3430	heel, counter, plastic reinforced	\$44.00
L3440	heel, counter, leather reinforced	\$35.00
L3500	miscellaneous shoe addition, insole, leather	BR
L3510	miscellaneous shoe addition, insole, rubber	BR
L3520	miscellaneous shoe addition, insole, felt covered with leather	BR
L3530	miscellaneous shoe addition, sole, half	BR
L3540	miscellaneous shoe addition, sole, full	BR
L3550	miscellaneous shoe addition, toe tap, standard	BR
L3560	miscellaneous shoe addition, toe tap, horseshoe	BR
L3570	miscellaneous shoe addition, special extension to instep	BR
L3580	miscellaneous shoe addition, convert instep to velcro closure	BR
L3590	miscellaneous shoe addition, convert firm shoe counter to soft	BR
L3595	miscellaneous shoe addition, march bar	BR
L3650	so, figure of eight design abduction restrainer	\$37.82
L3660	so, figure of eight design abduction restrainer, canvas and	\$65.54
L3670	so, acromio/clavicular (canvas and webbing type)	\$72.11
L3700	eo, elastic with stays	\$44.51
L3710	eo, elastic with metal joints	\$78.83
L3720	eo, double upright with forearm/arm cuffs, free motion	\$556.10
L3730	eo, double upright with forearm/arm cuffs, extension/flexion	\$766.44
L3740	eo, double upright with forearm/arm cuffs, adjustable position	\$908.66
L3800	whfo, short opponens, no attachments	\$140.00
L3805	whfo, long opponens, no attachment	\$256.00
L3810	whfo, addition to short and long opponens, thumb abduction	\$55.09
L3815	whfo, addition to short and long opponens, second m.p.	\$51.16
L3820	whfo, addition to short and long opponens, i.p. extension	\$87.86
L3825	whfo, addition to short and long opponens, m.p. extension stop	\$55.14
L3830	whfo, addition to short and long opponens, m.p. extension	\$71.98
L3835	whfo, addition to short and long opponens, m.p. spring	\$78.02

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
		Map
L3840	whfo, addition to short and long opponens, spring swivel thumb	\$53.45
L3845	whfo, addition to short and long opponens, thumb i.p. extension	\$69.02
L3850	whfo, addition to short and long opponens, action wrist, with	\$98.59
L3855	whfo, addition to short and long opponens, adjustable m.p.	\$99.38
L3860	whfo, add. To short and long opponens, adjustable m.p. flexion	\$136.03
L3900	whfo, dynamic flexor hinge, reciprocal wrist extension/flexion,	\$1,396.48
L3901	whfo, dynamic flexor hinge, reciprocal wrist extension/flexion,	\$1,481.20
L3902	whfo, external powered, compressed gas	\$2,137.19
L3904	whfo, external powered, electric	\$2,354.94
L3906	whfo, wrist gauntlet, custom fabricated	\$384.00
L3907	whfo, wrist gauntlet with thumb spica, custom fabricated	\$406.00
L3908	whfo, wrist extension control cock-up, prefabricated	\$38.21
L3910	whfo, swanson design	\$253.61
L3912	whfo, flexion glove with elastic finger control	\$69.00
L3914	whfo, wrist extension cock-up, prefabricated	\$62.00
L3916	whfo, wrist extension cock-up, with outrigger, prefabricated	\$109.00
L3918	whfo, knuckle bender, prefabricated	\$64.00
L3920	whfo, knuckle bender, with outrigger, prefabricated	\$90.00
L3922	whfo, knuckle bender, two segment to flex joints, prefabricated	\$75.02
L3924	whfo, oppenheimer, prefabricated	\$88.95
L3926	whfo, thomas suspension, prefabricated	\$71.96
L3928	whfo, finger extension, with clock spring, prefabricated	\$43.89
L3930	whfo, finger extension, with wrist support, prefabricated	\$50.94
L3932	whfo, safety pin, spring wire, prefabricated	\$38.12
L3934	whfo, safety pin, modified, prefabricated	\$40.91
L3936	whfo, palmer, prefabricated	\$75.73
L3938	whfo, dorsal wrist, prefabricated	\$74.25
L3940	whfo, dorsal wrist, with outrigger attachment, prefabricated	\$83.41
L3942	whfo, reverse knuckle bender, prefabricated	\$62.14
L3944	whfo, reverse knuckle bender, with outrigger, prefabricated	\$78.52
L3946	whfo, composite elastic, prefabricated	\$59.28
L3948	whfo, finger knuckle bender, prefabricated	\$46.85
L3950	whfo, combination oppenheimer, with knuckle bender and two	\$126.68
L3952	whfo, combination oppenheimer, with reverse knuckle and two	\$141.50
L3954	whfo, spreading hand, prefabricated	\$77.63
L3960	sewho, abduction positioning, airplane design, prefabricated	\$505.85
L3962	sewho, abduction positioning, erbs palsy design, prefabricated	\$457.52
L3963	sewho, molded shoulder, arm, forearm, and wrist with	\$1,063.83
L3964	seo, mobile arm support attached to wheelchair, balanced, adj.	\$501.52
L3965	seo, mobile arm support attached to wheelchair, balanced, adj.	\$772.40

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L3966	seo, mobile arm support attached to wheelchair, balanced,	\$613.07
L3968	seo, mobile arm support attached to wheelchair, balanced and,	\$713.05
L3969	seo, mobile arm support, monosuspension arm and hand support,	\$563.81
L3970	seo, addition to mobile arm support, elevating proximal arm	\$193.93
L3972	seo, addition to mobile arm support, offset or lateral rocker	\$178.22
L3974	seo, addition to mobile arm support, supinator	\$109.98
L3980	upper extremity fracture orthosis, humeral, prefabricated	\$197.13
L3982	upper extremity fracture orthosis, radius/ulnar, prefabricated	\$238.05
L3984	upper extremity fracture orthosis, wrist, prefabricated	\$219.47
L3985	upper extremity fracture orthosis, forearm, hand with wrist hinge,	\$496.93
L3986	upper extremity fracture orthosis, combination of humeral,	\$476.56
L3995	addition to upper extremity orthosis, sock, fracture or equal,	\$20.85
L3999	upper limb orthosis, not otherwise specified	BR
L4000	replace girdle for milwaukee orthosis	\$1,107.83
L4010	replace trilateral socket brim	\$942.50
L4020	replace quadrilateral socket brim, molded to patient model	\$748.37
L4030	replace quadrilateral socket brim, custom fitted	\$438.67
L4040	replace molded thigh lacer	\$354.66
L4045	replace nonmolded thigh lacer	\$285.01
L4050	replace molded calf lacer	\$358.70
L4055	replace nonmolded calf lacer	\$232.27
L4060	replace high roll cuff	\$276.12
L4070	replace proximal and distal upright for kafo	\$244.52
L4080	replace metal bands kafo, proximal thigh	\$87.00
L4090	replace metal bands kafofo, calf or distal thigh	\$78.46
L4100	replace leather cuff kafo, proximal thigh	\$90.62
L4110	replace leather cuff kafofo, calf or distal thigh	\$73.68
L4130	replace pretibial shell	\$431.00
L4210	repair of orthotic device, repair or replace minor parts	BR
L4350	pneumatic ankle control splint (e.g., aircast), prefabricated	\$58.25
L4360	pneumatic walking splint (e.g., aircast), prefabricated	\$180.43
L4370	pneumatic full leg splint (e.g., aircast), prefabricated	\$123.02
L4380	pneumatic knee splint (e.g., aircast), prefabricated	\$69.99
L5000	partial foot, shoe insert with longitudinal arch, toe filler	\$400.00
L5010	partial foot, molded socket, ankle height, with toe filler	\$1,217.00
L5020	partial foot, molded socket, tibial tubercle height, with toe	\$2,226.00
L5050	ankle, symes, molded socket, sach foot	\$2,231.00
L5060	ankle, symes, metal frame, molded leather socket, articulated	\$2,691.00
L5100	below knee, molded socket, shin, sach foot	\$2,499.00
L5105	below knee, plastic socket, joints and thigh lacer, sach foot	\$3,215.69

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
		Map
L5150	knee disarticulation (or through knee), molded socket, external	\$3,599.00
L5160	knee disarticulation, (or through knee), molded socket, bent,	\$3,869.00
L5200	above knee, molded socket, single axis constant friction knee,	\$3,081.00
L5210	above knee, short prosthesis, no knee joint ("stubbies"), with,	\$2,332.00
L5220	above knee, short prosthesis, no knee joint ("stubbies"),	\$2,592.00
L5230	above knee, for proximal femoral focal deficiency, constant	\$4,198.00
L5250	hip dis-articulation, canadian type; molded socket, hip joint,	\$4,802.00
L5270	hip dis-articulation, tilt table type, molded socket, locking	\$4,760.75
L5280	hemipelvectomy, canadian type; molded socket, hip joint, single	\$4,713.13
L5301	below knee, molded socket, shin, sach foot, endoskeletal system	\$2,612.75
L5311	knee disarticulation, molded socket, enternal knee joints, shin	\$3,859.00
L5321	above knee, molded socket, open end, sach foot, endoskeletal,	\$3,815.00
L5331	hip disarticlation, canadian type, molded socket, endoskeletal	\$5,450.14
L5341	hemipelvectomy, canadian type, molded socket, endoskeletal, hip	\$5,823.31
L5400	immediate post-surgical or early fitting, application of	\$1,261.00
L5410	immediate post-surgical or early fitting, application of	\$333.00
L5420	immediate post-surgical or early fitting, application of	\$1,547.71
L5430	immediate post-surgical or early fitting, application of	\$420.12
L5450	immediate post-surgical or early fitting, application of non-	\$363.27
L5460	immediate post-surgical or early fitting, application of non-	\$476.46
L5500	initial below knee "ptb" type socket, "usmc" or equal pylon, no	\$1,262.00
L5505	initial, above knee-knee dis-articulation, ischial level	\$1,685.00
L5510	preparatory, below knee "ptb" type socket, sach foot, plaster	\$1,535.00
L5520	preparatory, below knee "ptb" type socket, sach foot,	\$1,347.00
L5530	preparatory, below knee "ptb" type socket, no cover, sach foot,	\$1,752.00
L5535	preparatory, below knee "ptb" type socket, no cover, sach foot,	\$1,569.73
L5540	preparatory, below knee "ptb" type socket, no cover, sach foot,	\$1,765.00
L5570	preparatory, above knee-knee disarticulation, ischial	\$1,840.00
L5580	preparatory, above knee-knee disarticulation, ischial	\$2,352.00
L5585	preparatory, above knee-knee disarticulation, ischial	\$2,696.00
L5590	preparatory, above knee-knee disarticulation, ischial	\$2,225.22
L5595	preparatory, hip disarticulation-hemipelvectomy, pylo	\$3,727.16
L5600	preparatory, hip disarticulation-hemipelvectomy, pylon,	\$4,115.89
L5610	addition to lower extremity, endoskeletal above	\$1,916.47
L5611	addition to lower extremity, endoskeletal system above	\$1,491.40
L5613	addition to lower extremity, endoskeletal above, 4ar lin	\$2,268.50
L5614	addition to lower extremity, above knee--knee disarticula	\$3,508.49
L5616	addition to lower extremity, above knee, universal mult	\$1,257.18
L5618	addition to lower extremity, test socket, symes	\$654.32
L5620	addition to lower extremity, test socket, below knee	\$533.41

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L5622	addition to lower extremity, test socket, knee disarticulation	\$729.81
L5624	addition to lower extremity, test socket, above knee	\$635.07
L5626	addition to lower extremity, test socket, hip disarticulation	\$777.71
L5628	addition to lower extremity, test socket, hemipelvectomy	\$775.86
L5629	addition to lower extremity, below knee, acrylic socket	\$220.64
L5630	addition to lower extremity, symes type, expandable wall socket	\$415.43
L5631	addition to lower extremity, above knee or	\$305.04
L5632	addition to lower extremity, symes type, "ptb" brim d	\$205.52
L5634	addition to lower extremity, symes type, posterior opening	\$281.57
L5636	addition to lower extremity, symes type, medial opening socket	\$235.86
L5637	addition to lower extremity, below knee, total contact	\$294.15
L5638	addition to lower extremity, below knee, leather socket	\$450.48
L5639	addition to lower extremity, below knee, wood socket	\$1,037.83
L5640	addition to lower extremity, knee disarticulation, leather	\$591.89
L5642	addition to lower extremity, above knee, leather socket	\$573.50
L5643	addition to lower extremity, hip disarticulation, flexible	\$1,440.73
L5644	addition to lower extremity, above knee, wood socket	\$546.73
L5645	addition to lower extremity, below knee, flexible inner socket,	\$748.26
L5646	addition to lower extremity, below knee, air cushion socket	\$507.18
L5647	addition to lower extremity, below knee, suction socket	\$736.32
L5648	addition to lower extremity, above knee, air cushion socket	\$609.43
L5649	addition to lower extremity, ischial containment/narrow m-l	\$1,882.67
L5650	addition to lower extremity, total contact, above knee or knee	\$451.88
L5651	addition to lower extremity, above knee, flexible inner socket,	\$1,111.63
L5652	addition to lower extremity, suction suspension, above knee or	\$606.28
L5653	addition to lower extremity, knee disarticulation, expandable	\$661.74
L5654	addition to lower extremity, socket insert, symes (kemblo,	\$426.49
L5655	addition to lower extremity, socket insert, below knee (kemblo,	\$348.15
L5656	addition to lower extremity, socket insert, knee	\$343.38
L5658	addition to lower extremity, socket insert, above knee (kemblo,	\$336.56
L5660	addition to lower extremity, socket inset, symes, silicone gel	\$533.65
L5661	addition to lower extremity, socket insert, multidurometer,	\$563.29
L5662	addition to lower extremity, socket insert, below knee,	\$489.35
L5663	addition to lower extremity, socket insert, knee	\$637.86
L5664	addition to lower extremity, socket insert, above knee,	\$614.54
L5665	addition to lower extremity, socket insert, multidurometer,	\$473.96
L5666	addition to lower extremity, below knee, cuff suspension	\$64.80
L5668	addition to lower extremity, below knee, molded distal cushion	\$93.48
L5670	addition to lower extremity, below knee, molded supracondylar	\$300.76
L5672	addition to lower extremity, below knee, removable medial brim	\$276.02

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes) A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	Map
L5674	addition to lower extremity, below knee, latex sleeve	\$48.81
L5675	addition to lower extremity, below knee, latex sleeve	\$66.16
L5676	addition to lower extremity, below knee, knee joints, single	\$335.44
L5677	addition to lower extremity, below knee, knee joints,	\$456.40
L5678	addition to lower extremity, below knee, joint covers, pair	\$30.33
L5680	addition to lower extremity, below knee, thigh lacer, nonmolded	\$281.74
L5682	addition to lower extremity, below knee, thigh lacer,	\$578.90
L5684	addition to lower extremity, below knee, fork strap	\$44.54
L5686	addition to lower extremity, below knee, back check (extension	\$47.29
L5688	addition to lower extremity, below knee, waist belt, webbing	\$56.53
L5690	addition to lower extremity, below knee, waist belt, padded and	\$90.58
L5692	addition to lower extremity, above knee, pelvic control belt,	\$123.00
L5694	addition to lower extremity, above knee, pelvic control belt,	\$167.93
L5695	addition to lower extremity, above knee, pelvic control, sleeve	\$150.96
L5696	addition to lower extremity, above knee or knee	\$171.28
L5697	addition to lower extremity, above knee or knee	\$74.32
L5698	addition to lower extremity, above knee or knee	\$96.56
L5699	all lower extremity prostheses, shoulder harness	\$142.40
L5700	replacement, socket, below knee, molded to patient model	\$2,534.95
L5701	replacement, socket, above knee/knee disarticulation including	\$3,147.36
L5702	replacement, socket, hip disarticulation, including hip joint,	\$4,021.66
L5704	replacement, custom shaped protective cover, below knee	\$436.72
L5705	replacement, custom shaped protective cover, above knee	\$800.64
L5706	replacement, custom shaped protective cover, knee	\$780.94
L5707	replacement, custom shaped protective cover, hip	\$1,049.19
L5710	addition, exoskeletal knee-shin system, single axis, manual	\$332.93
L5711	addition, exoskeletal knee-shin system, single axis, manual lo	\$483.34
L5712	addition, exoskeletal knee-shin system, single axis, friction	\$398.87
L5714	addition, exoskeletal knee-shin system, single axis, variable	\$387.18
L5716	addition, exoskeletal knee-shin system, polycentric mechanical	\$674.65
L5718	addition, exoskeletal knee-shin system, polycentric, friction c	\$843.24
L5722	addition, exoskeletal knee-shin system, single axis, pneumatic	\$835.75
L5724	addition, exoskeletal knee-shin system, single axis, fluid	\$1,397.20
L5726	addition, exoskeletal knee-shin system, single axis, external	\$1,610.24
L5728	addition, exoskeletal knee-shin system, single axis, fluid	\$1,851.35
L5780	addition, exoskeletal knee-shin system, single axis,	\$1,059.79
L5785	addition, exoskeletal system, below knee, ultra-light material	\$480.92
L5790	addition, exoskeletal system, above knee, ultra-light material	\$665.57
L5795	addition, exoskeletal system, hip disarticulation, ultra-light	\$993.86
L5810	addition, endoskeletal knee-shin system, single axis, manual	\$450.67

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L5811	addition, endoskeletal knee-shin system, single axis, manual	\$675.10
L5812	addition, endoskeletal knee-shin system, single axis friction	\$495.00
L5816	addition, endoskeletal knee-shin system, polycentric mechanical	\$710.00
L5818	addition, endoskeletal knee-shin system, polycentric, friction	\$888.94
L5822	addition, endoskeletal knee-shin system, single axis, pneumatic	\$1,576.30
L5824	addition, endoskeletal knee-shin system, single axis, fluid	\$1,400.00
L5828	addition, endoskeletal knee-shin system, single axis, fluid	\$2,263.39
L5830	addition, endoskeletal knee-shin system, single axis,	\$1,756.46
L5840	addition, endoskeletal knee-shin system, single axis,	\$1,980.00
L5850	addition, endoskeletal system, above knee or hip	\$118.42
L5855	addition, endoskeletal system, hip disarticulation, mechanical	\$285.88
L5910	addition, endoskeletal system, below knee, alignable system	\$335.26
L5920	addition, endoskeletal system, above knee or hip	\$491.14
L5925	addition, endoskeletal system, above knee, knee disarticulation	\$280.00
L5940	addition, endoskeletal system, below knee, ultra-light material	\$464.30
L5950	addition, endoskeletal system, above knee, ultra-light material	\$720.17
L5960	addition, endoskeletal system, hip disarticulation, ultra-light	\$892.37
L5962	addition, endoskeletal system, below knee, flexible protective	\$490.00
L5964	addition, endoskeletal system, above knee, flexible protective	\$798.56
L5966	addition endoskeletal system, hip disarticulation, flexible	\$1,035.31
L5970	all lower extremity prostheses, foot, external keel, sach foot	\$187.99
L5972	all lower extremity prostheses, flexible keel foot (safe, sten,	\$326.23
L5974	all lower extremity prostheses, foot, single axis ankle/foot	\$215.70
L5976	all lower extremity prostheses, energy storing foot (seattl	\$451.39
L5978	all lower extremity prostheses, foot, multixial ankle/foot	\$270.13
L5979	all lower extremity prostheses, multixial ankle/foot, dynami	\$2,090.00
L5980	all lower extremity prostheses, flex-foot system	\$2,917.79
L5981	all lower extremity prostheses, flex-walk system or equal	\$2,382.65
L5982	all exoskeletal lower extremity prostheses, axial rotation unit	\$535.13
L5984	all endoskeletal lower extremity prostheses, axial rotatio	\$527.33
L5986	all lower extremity prostheses, multixial rotation unit ("mcp	\$586.57
L5999	lower extremity prosthesis, not otherwise classified	BR
L6000	partial hand, robinids, thumb remaining (or equal)	\$1,229.90
L6010	partial hand, robinids, little and/or ring finger remaining	\$1,368.70
L6020	partial hand, robon aids, no finger remaining (or equal)	\$1,276.09
L6050	wrist disarticulation, molded socket, flexible elbow hinges	\$2,263.00
L6055	wrist disarticulation, molded socket with expandable interface,	\$2,450.75
L6100	below elbow, molded socket, flexible elbow hinge, triceps pad	\$2,229.00
L6110	below elbow, molded socket (muenster or northwestern suspension	\$2,284.04
L6120	below elbow, molded double wall split socket, step-up hinges,	\$2,202.07

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
		Map
L6130	below elbow, molded double wall split socket, stump activated	\$2,396.27
L6200	elbow disarticulation, molded socket, outside locking hinge,	\$2,982.00
L6205	elbow disarticulation, molded socket with expandable interface,	\$3,370.85
L6250	above elbow, molded double wall socket, internal locking elbow,	\$3,267.79
L6300	shoulder disarticulation, molded socket, shoulder bulkhead,	\$3,448.64
L6310	shoulder disarticulation, passive restoration (complete	\$2,809.00
L6320	shoulder disarticulation, passive restoration (shoulder cap	\$1,581.89
L6350	interscapular thoracic, molded socket, shoulder bulkhead,	\$3,625.73
L6360	interscapular thoracic, passive restoration (complete	\$2,948.39
L6370	interscapular thoracic, passive restoration (shoulder cap only)	\$1,880.09
L6380	immediate post-surgical or early fitting, application of	\$1,130.00
L6382	immediate post-surgical or early fitting, application of	\$1,520.00
L6384	immediate post-surgical or early fitting, application of	\$1,764.86
L6386	immediate post-surgical or early fitting, each additional cast	\$371.72
L6388	immediate post-surgical or early fitting, application of rigid	\$406.94
L6400	below elbow, molded socket, endoskeletal system, including soft	\$2,147.89
L6450	elbow disarticulation, molded socket, endoskeletal system,	\$2,853.88
L6500	above elbow, molded socket, endoskeletal system, including soft	\$2,856.22
L6550	shoulder disarticulation, molded socket, endoskeletal system,	\$3,529.76
L6570	interscapular thoracic, molded socket, endoskeletal system,	\$4,051.49
L6580	preparatory, wrist disarticulation or below elbow, single wall	\$1,446.95
L6582	preparatory, wrist disarticulation or below elbow, single wall	\$1,273.99
L6584	preparatory, elbow disarticulation or above elbow, single wa	\$1,894.64
L6586	preparatory, elbow disarticulation or above elbow, single wa	\$1,734.41
L6588	preparatory, shoulder disarticulation or interscapul	\$2,616.40
L6590	preparatory, shoulder disarticulation or interscapul	\$2,435.32
L6600	upper extremity additions, polycentric hinge, pair	\$173.63
L6605	upper extremity additions, single pivot hinge, pair	\$171.44
L6610	upper extremity additions, flexible metal hinge, pair	\$154.12
L6615	upper extremity addition, disconnect locking wrist unit	\$160.80
L6616	upper extremity addition, additional disconnect insert f	\$60.04
L6620	upper extremity addition, flexion-friction wrist unit	\$280.66
L6623	upper extremity addition, spring assisted rotational wrist un	\$593.77
L6625	upper extremity addition, rotation wrist unit with cable lock	\$492.31
L6628	upper extremity addition, quick disconnect hook adapter, or equal	\$443.44
L6629	upper extremity addition, quick disconnect lamination coll	\$135.43
L6630	upper extremity addition, stainless steel, any wrist	\$529.70
L6632	upper extremity addition, latex suspension sleeve, each	\$60.14
L6635	upper extremity addition, lift assist for elbow	\$185.00
L6637	upper extremity addition, nudge control elbow lock	\$339.89

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L6640	upper extremity addition, shoulder abduction joint, pair	\$259.30
L6641	upper extremity addition, excursion amplifier pulley type	\$148.50
L6642	upper extremity addition, excursion amplifier level type	\$201.28
L6645	upper extremity addition, shoulder flexion abduction join	\$295.49
L6650	upper extremity addition, shoulder universal joint, each	\$313.32
L6655	upper extremity addition, standard control cable, extra	\$69.53
L6660	upper extremity addition, heavy duty control cable	\$84.96
L6665	upper extremity addition, teflon, or equal cable lining	\$42.64
L6670	upper extremity addition, hook to hand, cable adapter	\$44.39
L6672	upper extremity addition, harness, chest or shoulder, saddle	\$156.07
L6675	upper extremity addition, harness, figure of eight type, for	\$111.16
L6676	upper extremity addition, harness, figure of ei	\$112.26
L6680	upper extremity addition, test socket, wrist disar	\$396.63
L6682	upper extremity addition, test socket, elbow disar	\$492.52
L6684	upper extremity addition, test socket, shoulder di	\$575.62
L6686	upper extremity addition, suction socket	\$546.47
L6687	upper extremity addition, frame type socket, b	\$485.00
L6688	upper extremity addition, frame type socket, a	\$490.36
L6689	upper extremity addition, frame type soc	\$623.71
L6690	upper extremity addition, frame type socket,	\$636.49
L6691	upper extremity addition, removable insert, each	\$375.00
L6692	upper extremity addition, silicone gel insert or equal, each	\$517.66
L6700	terminal device, hook dorrance, or equal, model #3	\$480.17
L6705	terminal device, hook dorrance, or equal, model #5	\$281.90
L6710	terminal device, hook, dorrance, or equal, model #5x	\$456.45
L6715	terminal device, hook, dorrance, or equal, model #5xa	\$435.00
L6720	terminal device, hook, dorrance, or equal, model #6	\$789.68
L6725	terminal device, hook, dorrance, or equal, model #7	\$465.24
L6730	terminal device, hook, dorrance, or equal, model #7lo	\$591.50
L6735	terminal device, hook, dorrance, or equal, model #8	\$275.82
L6740	terminal device, hook, dorrance, or equal, model #8x	\$359.60
L6745	terminal device, hook, dorrance, or equal, model #88x	\$329.03
L6750	terminal device, hook, dorrance, or equal, model #10p	\$325.22
L6755	terminal device, hook, dorrance, or equal, model #10x	\$324.30
L6765	terminal device, hook, dorrance, or equal, model #12p	\$338.82
L6770	terminal device, hook, dorrance, or equal, model #99x	\$326.63
L6775	terminal device, hook, dorrance, or equal, model #555	\$387.01
L6780	terminal device, hook, dorrance, or equal, model #ss555	\$413.69
L6790	terminal device, hook, accu hook or equal	\$418.27
L6795	terminal device, hook, 2 load or equal	\$1,145.60

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L6800	terminal device, hook, aprl vc or equal	\$937.88
L6805	terminal device, modifier wrist flexion unit	\$314.94
L6806	terminal device, hook, trs grip, vc	\$1,219.79
L6809	terminal device, hook, trs super sport, passive	\$343.46
L6810	terminal device, pincher tool, otto bock or equal	\$172.66
L6825	terminal device, hand, dorrance, vo	\$955.02
L6830	terminal device, hand, aprl, vc	\$1,253.51
L6835	terminal device, hand, sierra, vo	\$1,091.93
L6840	terminal device, hand, becker imperial	\$758.59
L6845	terminal device, hand, becker lock grip	\$704.22
L6850	terminal device, hand, becker pylite	\$637.78
L6855	terminal device, hand, robinids, vo	\$811.19
L6860	terminal device, hand, robinids, vo soft	\$615.22
L6865	terminal device, hand, passive hand	\$301.42
L6875	terminal device, hand, bock vc	\$719.47
L6880	terminal device, hand, bock vo	\$466.76
L6890	terminal device, glove for above hands, production glove	\$190.00
L6895	terminal device, glove for above hands, custom glove	\$732.76
L6900	hand restoration (casts, shading and measuremen	\$1,989.50
L6905	hand restoration (casts, shading and measuremen	\$1,990.23
L6910	hand restoration (casts, shading and measuremen	\$2,001.88
L6915	hand restoration (shading and measuremen	\$774.57
L6920	wrist disarticulation, external power, self-su	\$6,434.34
L6925	wrist disarticulation, external power, self-su	\$6,874.02
L6930	below elbow, external power, self-suspended inner socket,	\$6,197.18
L6935	below elbow, external power, self-suspended inner socket,	\$6,841.72
L6940	elbow disarticulation, external power, molded inner socket,	\$8,002.61
L6945	elbow disarticulation, external power, molded inner socket,	\$8,927.91
L6950	above elbow, external power, molded inner socket, removable	\$7,987.74
L6955	above elbow, external power, molded inner socket, removable	\$9,263.27
L6960	shoulder disarticulation, external power, molded inner socket,	\$9,744.62
L6965	shoulder disarticulation, external power, molded inner	\$11,544.00
L6970	interscapular-thoracic, external power, molded inner	\$12,356.57
L6975	interscapular-thoracic, external power, molded inner	\$13,619.84
L7010	electronic hand, otto bock, steeper or equal, switch controlled	\$3,174.94
L7015	electronic hand, system teknik, variety village or equal, switc	\$5,611.94
L7020	electronic greifer, otto bock or equal, switch controlled	\$3,466.69
L7025	electronic hand, otto bock or equal, myoelectronically	\$3,428.95
L7030	electronic hand, system teknik, variety village or equal,	\$5,488.37
L7035	electronic greifer, otto bock or equal, myoelectronically	\$3,648.62

Code	Abbreviated Orthotic and Prosthetic procedures (L-Codes)	Map
	A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107	
L7040	prehensile actuator, hosmer or equal, switch controlled	\$2,609.59
L7170	electronic elbow, boston or equal, switch controlled	\$5,427.59
L7180	electronic elbow, boston, utah or equal, myoelectro	\$29,891.81
L7260	electronic wrist rotator, otto bock or equal	\$1,821.71
L7261	electronic wrist rotator, for utah arm	\$3,610.95
L7266	servo control, steeper or equal	\$916.48
L7272	analogue control, unb or equal	\$1,812.94
L7274	proportional control, 12 volt, utah or equal	\$5,621.72
L7360	six volt battery, otto bock or equal, each	\$240.00
L7362	battery charger, six volt, otto bock or equal	\$242.00
L7364	twelve volt battery, utah or equal, each	\$392.77
L7366	battery charger, 12 volt, utah or equal	\$540.20
L7499	unlisted procedures for upper extremity prosthesis	BR
L7500	repair of prosthetic device, hourly rate	\$80.00
L7510	repair prosthetic device, repair or replace minor parts	BR
L8100	gradient compression stocking, below knee, medium weight, each	BR
L8110	gradient compression stocking, below knee, heavy weight, each	BR
L8120	gradient compression stocking, (linton or equal), each thigh	BR
L8130	gradient compression stocking, thigh length	BR
L8140	gradient compression stocking, thigh length	BR
L8150	gradient compression stocking, thigh length	BR
L8160	gradient compression stocking, full-length, each	BR
L8170	gradient compression stocking, full-length, chap style each	BR
L8180	gradient compression stocking,	BR
L8190	gradient compression stocking, waist length each	BR
L8200	gradient compression stocking, waist length, each	BR
L8210	gradient compression stocking, custom-made	BR
L8220	gradient compression, elastic stocking, lymphedema	BR
L8300	truss, single with standard pad	\$58.56
L8310	truss, double with standard pads	\$92.46
L8320	truss, addition to standard pad, water pad	\$37.11
L8330	truss, addition to standard pad, scrotal pad	\$34.27
L8400	prosthetic sheath, below knee, each	\$23.02
L8410	prosthetic sheath, above knee, each	\$19.18
L8415	prosthetic sheath, upper limb, each	\$19.84
L8420	prosthetic sock, multiple ply, below knee, each	\$18.01
L8430	prosthetic sock, multiple ply, above knee, each	\$20.50
L8435	prosthetic sock, multiple ply, upper limb, each	\$19.46
L8440	prosthetic shrinker, below knee, each	\$38.71
L8460	prosthetic shrinker, above knee, each	\$61.69

Abbreviated Orthotic and Prosthetic procedures (L-Codes)		
A complete listing of procedures and codes is found in HCPCS as adopted by reference in R 418.10107		
Code		Map
L8465	prosthetic shrinker, upper limb, each	\$45.16
L8470	stump sock, single ply, fitting, below knee, each	\$6.18
L8480	stump sock, single ply, fitting, above knee, each	\$8.52
L8485	stump sock, single ply, fitting, upper limb, each	\$10.17
L8490	addition to prosthetic sheath/sock, air seal suction retent.	\$134.87
L8499	unlisted procedure for miscellaneous prosthetic services	BR
L8500	artificial larynx, any type	BR
L8501	tracheostomy speaking valve	BR
L8610	ocular	BR
L8699	prosthetic implant, not otherwise specified	BR

History: 2003 MR 4, Eff. Mar. 4, 2003; 2004 MR 5, Eff. Feb. 20, 2004.