LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Detail Reference Guide to
Determining CMS Medicare + 30%
for Michigan Workers' Compensation
Maximum Medical Reimbursement Fee Schedules
Effective: 12/26/2012

- ***Note**: Codes listed with "0" or not listed are BR (By Report). A BR procedure is reimbursed at the provider's usual and customary charge or reasonable amount, defined in the definition section of the Health Care Services Rules, whichever is less.*
- *The absence or presence of a code does not indicate workers' compensation coverage.*
- *Please refer to the Health Care Services Manual for additional information.*

AMBULATORY SURGICAL CENTER

Payment for surgical procedures performed in Ambulatory Surgical Center (ASC) or Free Standing Outpatient Facility (FSOF); Medicare ASC-Reimbursed Drugs and Biologicals (unless otherwise paid under OPPS system); Pass-Through Items:

FORMULA:
Calculate the Michigan Maximum Allowable Payment (MAP) using the following formula(s):
(Formula component 1.30 below represents Medicare + 30%)

Medicare Payment Amount fee, rounded x 1.30 = Michigan MAP, rounded

IMPORTANT NOTES:

1. The *Ambulatory Surgical Center (ASC) Payment. Drug & Biological reimbursement rates* tables are available on our website.

2. Calculate the fee by taking the Medicare fee from the column labeled *Payment* on appropriate tab (surgical or ancillary*)*, round and multiply by 1.30 to get the Michigan Maximum Allowable Payment, rounded.

3. Rule 418.101023(2) Reimbursement for surgical procedures performed in a ASC or FSOF shall be determined by using the CMS ASC rate that is published in the Federal Register. The formula for determining the maximum allowable paid (MAP) for a surgical procedure in an ASC or FSOF is determined by multiplying the (Medicare ASC rate) X (1.30). The MAP shall be published in the health care services fee schedule.
(2) 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 shall not un-bundle surgical procedure codes when billing the services.
(3) 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.
(4) Implants are included in the maximum allowable paid unless the CMS list it as a pass through item. Pass through items will be listed in the health care service manual. If an item is implanted during the surgical procedure

and the ASC or FSOF bills the implant and includes the copy of the invoice, then the implant shall be reimbursed at the cost of the implant plus a percent markup as follows:

(a) Cost of implant: $1.00 to $500.00 shall receive cost plus 50%.

(b) Cost of implant: $500.01 to $1000.00 shall receive cost plus 30%.

(c) Cost of implant: $1000.01 and higher shall receive cost plus 25%.

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

(6) 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 post-operative radiology services may be globally billed.

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