

**Reference Guide to Calculate Michigan
Workers' Compensation Maximum Allowable Payment for Durable Medical Equipment,
Prosthetics, Orthotics, and Supplies
Fee Schedule Effective: 12/26/2012**

- **Note:** A By Report 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.

**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
(DMEPOS)**

Calculate the Michigan Maximum Allowable Payment (MAP) using the following formula:

**Medicare payment amount for DMEPOS x 1.05 (Michigan Multiplier) = Michigan
MAP**

If no Medicare payment amount for DME or Supplies calculate the MAP using the following formula:

Invoice Amount for DME or Supplies + Percent Mark-Up = Michigan MAP

Factors used to calculate DMEPOS MAP:

- 1.05 represents Michigan Medicare payment amount plus 5%
- If there is no Michigan Medicare payment amount for Prosthetics or Orthotics these shall be reimbursed By Report.
- Unless otherwise indicated in a separate rule, if there is no Michigan Medicare payment amount for DME or supplies, reimbursement shall be invoice cost plus a percent mark-up as follows:
 - Invoice cost of \$35.00 or less shall receive provider charge
 - Invoice cost of \$35.01 to \$100 shall receive cost plus 50%
 - Invoice cost of \$100.01 to \$250.00 shall receive cost plus 30%
 - Invoice cost of \$250.01 to \$700.00 shall receive cost plus 25%
 - Invoice cost of \$700.01 or higher shall receive cost plus 20%

Health Care Services Rules for reference:

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

Rule 106.

(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 R418.10106.
- (b) All CPT® procedure codes that do not have an assigned relative value.

R418.10214 Orthotic and prosthetic equipment.

Rule 214. (1) A copy of a prescription by 1 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, appropriate L-codes or A4570 for a prefabricated orthosis.
- (4) An orthotist or prosthetist that is certified by the American board for certification in orthotics and prosthetics, shall bill orthosis and prostheses that are custom-fabricated, molded to the patient, or molded to a patient model. Licensed physical and licensed occupational therapists may bill orthoses using L-codes within their discipline's scope of practice. 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) If a licensed occupational therapist or licensed physical therapist constructs an extremity orthosis that is not adequately described by another L-code, then the therapist shall bill the service using procedure code L3999. The carrier shall reimburse this code as a "by report" or "BR" procedure. The provider shall include the following information with the bill:
 - (a) A description of the orthosis.
 - (b) The time taken to construct or modify the orthosis.
 - (c) The charge for materials, if applicable.
 - (6) L-code procedures shall include fitting and adjustment of the equipment.
 - (7) The health care services division shall publish the maximum allowable payments for L-code procedures in the manual separate from these rules. If an L-code procedure does not have an assigned maximum allowable payment, then the procedure shall be by report, "BR."
 - (8) 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.

R 418.10913 Billing for durable medical equipment and supplies.

Rule 913. (1) Durable medical equipment (DME) and supplies shall be billed using the appropriate descriptor from HCPCS, Medicare's National Level II codes, as referenced in R 418.10107, for the service. If the equipment or supply is billed using an unlisted or not otherwise specified code and the charge exceeds \$35.00, then an invoice shall be included with the bill.

- (2) Initial claims for rental or purchased DME shall be filed with a prescription for medical necessity, including the expected time span the equipment will be required.
- (3) Durable medical equipment may be billed as a rental or a purchase. If possible, the provider and carrier shall agree before dispensing the item as to whether it should be a rental or a purchased item. With the exception of oxygen equipment, rented DME is considered purchased equipment once the monthly rental allowance exceeds the purchase price or payment of 12 months rental, whichever comes first.
 - (a) If the worker's medical condition changes or does not improve as expected, then the rental may be discontinued in favor of purchase.
 - (b) If death occurs, rental fees for equipment will terminate at the end of the month and additional rental payment shall not be made.
 - (c) The return of rented equipment is the dual responsibility of the worker and the DME supplier. The carrier is not responsible and shall not be required to reimburse for additional rental periods solely because of a delay in equipment returns.
 - (d) Oxygen equipment shall be considered a rental as long as the equipment is medically necessary. The equipment rental allowance includes reimbursement for the oxygen contents.
- (4) A bill for an expendable medical supply shall include the brand name and the quantity dispensed.
- (5) A bill for a miscellaneous supply, for example; a wig, shoes, or shoe modification, shall be submitted on an invoice if the supplier is not listed as a health care professional.

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.

(e) Home health services.

(3) Orthotic and prosthetic procedures, L0000-L9999, shall be reimbursed by the carrier at Medicare plus 5%. The health care services division shall publish maximum allowable payments for L-code procedures in the manual separate from these rules. Orthotic and prosthetic procedures not included in the manual shall be considered by report procedures and require a written description accompanying the charges on the CMS-1500 claim form. The report shall include date of service, a description of the services(s) provided, the time involved, and the charge for materials and components

R 418.101003b Reimbursement for durable medical equipment and supplies.

Rule 1003b. (1) The carrier shall reimburse durable medical equipment (DME) and supplies at Medicare plus 5%. The health care services division shall publish the maximum allowable payments for DME and supplies in the manual separate from these rules.

(2) Rented DME shall be identified on the provider's bill by RR. Modifier NU will identify the item as purchased, new.

(3) If a DME or supply exceeding \$35.00 is not listed in the fee schedule, or if the service is billed with a not otherwise specified code, then reimbursement shall be invoice cost plus a percent mark-up as follows:

(a) Invoice cost of \$35.01 to \$100 shall receive cost plus 50%.

(b) Invoice cost of \$100.01 to \$250.00 shall receive cost plus 30%.

(c) Invoice cost of \$250.01 to \$700.00 shall receive cost plus 25%.

(d) Invoice cost of \$700.01 or higher shall receive cost plus 20%.