State of Michigan
Workers Compensation
Agency
Resolution, Rehabilitation and Rules Division
HEALTH CARE SERVICES RULES UPDATE
Effective January 13, 2017
HEALTH CARE SERVICES RULES

► Health Care Services Rules are the promulgated rules governing health care services under the Michigan Workers’ Disability Compensation Act of 1969.

► Health Care Services Rules can be identified by the R418. distinction.
HEALTH CARE SERVICES MANUAL

- Is designed to be user friendly.
- Any reference in the manual to “MCLA418” relates to the Michigan Workers’ Disability Compensation statute.
- Any conflicts between the language of the manual and the rules, the language of the rules controls.
WC–104B FORM

- The WC–104B was revised as of 09/2013.
- EVERYONE should be using this version.
- It is available on our website, www.michigan.gov/wca.
APPLICATION FOR MEDIATION OR HEARING – FORM B
Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
PO Box 30018, Lansing, MI 48909

☐ I hereby certify that we have consulted with Rules 1501 through 1544 and Parts 8 and 10 of the Workers’ Compensation Health Care Services Rules.

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

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<th>Date of 2nd Filing</th>
<th>Last Post Filing</th>
<th>Reason for Filing (see codes in legend)</th>
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☐ If the carrier involved in this case is currently being denied treatment as a result of this dispute, check the box on the left and provide a description of the needed treatment that is being denied in the box on the back.

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

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

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WO-1548 (Rev. 5/13)
WC-104B INFORMATION THAT NEEDS TO BE ACCURATE

- Employee name
- Full Social Security number
- Employee date of birth
- Employer information
- Date of injury
- Name of the insurance company, if one is being billed.
WHO: EMPLOYEE

- Use employees entire Social Security number.
- Do not use date of service as date of injury, unless services were rendered on the actual date of injury.
- County of injury.
- Who does the employee really work for?
- What is the employers name?
- Contact person/telephone number
WHO: CARRIER

- Coverage/Compliance at WCA
- Carrier vs. bill review company
- Is there an adjuster on the claim?
- Is the claim number for your date of injury?
- Telephone and extension number for the adjuster.
WHO: PROVIDER

- Applicant should be the person handling the hearing at the provider location.
- If represented by an attorney, we need their phone number.
- Attorney’s “P” number.
Why are you going to file a WC-104B?

- For assistance in resolving payment issues with the carrier.
- To be added as an intervening party if the case is in litigation.
- To get in front of the magistrate.
When are you going to file a WC–104B?

- No less than 60 days from the initial billing.
- When you learn a case is in litigation and there are outstanding balances.
- After request for reconsideration has been submitted without resolution.
What You Need to Know

- What services were rendered on the date of service.
- Original billed amount.
- Date & amount of any payment received.
- Date of first reconsideration.
- Who has contact been made with and their telephone & extension numbers.
- Outcome of the contact.
What We Need to Know

- Itemized dates of service, the amount of the bill.
- Date of 1st billing.
- Date of 2nd billing.
- Late fee: yes or no.
- Reason for filing.
What to do if a case is litigation

- If there are outstanding balances, file a WC-104B.
- Send copies of outstanding bills to the injured worker and their attorney.
- Obtain a copy of the Notice of Dispute.
- Submit bills to the injured workers health insurance.
Difference Between a Litigated Case and a Disputed Case

Litigated case
- WC-104A has been filed.
- Injured worker is pursing their claim through litigation.

Disputed case
- WC-107, Notice of Dispute, has been filed by the carrier.
- If the injured worker does not file a WC-104A, then in the eyes of the state, the dispute stands.
WC-104B Moves to the Magistrate

- Provider representative should come in for at least 1 hearing after pretrial.
- Discuss with magistrate and other attorneys.
- You cannot talk to the magistrate without other parties present.
- Bring copies of bills/medical records.
- Don’t depend on other counsel to defend your case.
Provider’s Request for Reconsideration

R418.101302

“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 portion of the bill.”
Carrier’s Response to Providers Request for Reconsideration

- R418.101303

- (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.
R418.101303

(2) A provider shall send its application for mediation or hearing to the agency within 30 days from the date of the receipt of a carrier’s denial of this provider’s request for reconsideration.
(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.
3% Late Penalty
(Provider)

- R418.10116(2)

- “If the provider has not received payment within 30 days of submitting the bill, then the provider shall resubmit the bill to the carrier and a 3% late fee.”
3% Late Penalty (Carrier)

“A carrier or designated agent shall make payments 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 of the providers charge, whichever is less, as required by these rules.”
3% Late Penalty
(Carrier)

- R418.10117(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 nonpayment of the bill is due to the dispute.”
No Record of Coverage

- Look at the employees address.
- Look at the employers address.
- Is there a claim under another states jurisdiction.
- Call the employer to determine if they have a workers’ comp policy.
Out of State Providers

R418.10106(2)

Out of state providers may or may not accept the map made in accordance with the Michigan fee schedule.

If an out of state facility refuses to negotiate fees, the carrier must reimburse the facility in accordance to the laws of the state where they are located and services were performed.
Jurisdiction

- Jurisdiction is forever.
- If the injured worker has a claim in another state, and subsequently moves to Michigan, the claim remains under the jurisdiction of the state of injury.
Providers

- Whether or not an injured worker disputes the carrier’s denial of a case by submitting a WC-104A form to the agency, the worker’s health insurance is responsible for the health services.
Facility vs Non-facility

- Facility services are generally provided in a hospital, outpatient surgery center or skilled nursing facility.
- Non-facility services are generally provided in physician offices, urgent care facilities, home care settings, etc.
- A hospital system owned office practice shall bill services on the CMS1500 form using the office site of service and shall not bill facility fees.
Requests for Existing Medical Records & Reports

- There is nothing in the HCS rules that precludes a carrier, 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.

- If a provider is requested by the carrier to prepare and submit a special written report in addition to the medical records, the provider shall bill special report using procedure code 99199-32 for special reports up to 3 pages in length. The carrier shall reimburse the provider $25.00 per page.

- Complex reports greater than 3 pages in length or record reviews shall be reimbursed on a contractual basis between the carrier and the provider.
Copy Fees

- Only those records for a specific date of injury are covered under the HCS rules.
- .45 cents per page plus actual cost of mailing.
- Administration charge for retrieval and copying: $2.50 for each 15 minute increment.
- For records other than those applying to the specific date of injury, the provider may bill their usual & customary charge.
- The rule does not pertain to medical record requested by subpoena that are part of litigation.
Withdrawing a WC–104B

- Sign the bottom of the hearing notice.
- Fax **ONLY** the signed hearing notice.
- Do not send a cover sheet, letter, copy of the WC–104B.
- Do not highlight on the hearing notice.
Claim Filing Limitations

- R418.10102

- A provider shall bill a carrier within one year of the date of service for consideration of payment.

- The one year filing rule shall not apply if the provider bills after the one year requirement of this rule due to litigation or subrogation.
What does “Claim” mean to you?
What does “Claim” mean to you?

Health Care Provider

- A “claim” is the bill that is submitted to the carrier for services rendered to the injured worker.

Carrier

- A “claim” is the file set up to investigate the alleged injury and pay the appropriate benefits, if owed.
Definitions
Custom compound

- R418.10108(n)

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

- RR418.1109(z)

- The initial evaluation by a carrier of the appropriateness in terms of both the level and quality of health care services, provided and injured employee, based on medically accepted standards.
-AD modifier. Indicates an anesthesiologist has provided medical supervision for more than 4 qualified individuals being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.
Global Surgical Procedure; Services Included

- R418.10401

- (1)(b) Subsequent to the decision for surgery, 1 related evaluation and management encounter on the date immediately prior to or on the date of the procedure is included. However, when an initial evaluation and management encounter occurs and the decision for surgery is made at that encounter, the evaluation and management service is payable in addition to the surgical procedure.
Reimbursements
Reimbursement for Anesthesia Services

- R418.101007

- If the anesthesiologist provides medical supervision for more than 4 concurrent anesthesia procedures, then the modifier shall be AD and the maximum payment shall be 3 base units.

- One time unit shall be paid if the anesthesiologist is present for induction of anesthesia services at $1.40 per minute.
Reimbursement of Dispensed Medications

- R418.101003a

- (1) Prescription medication shall be reimbursed at the average wholesale price (AWP) minus 10% as determined by Red Book or Medi-Span, plus a dispense fee.

- (a) The dispense fee for a brand name drug shall be $3.50 and shall be billed with WC700-B.
(b) The dispense fee for a generic drug shall be $5.50 and shall be billed with WC700-G.

(c) Reimbursement for repackaged pharmaceuticals shall be at a maximum reimbursement of AWP minus 10% based upon the original manufacturers NDC number as published by Red Book or Medi-Span, plus a dispense fee of $3.50 for brand name and $5.50 for generic.
(2) Over-the-counter (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 Red Book or Medi-Span or $2.50, whichever is greater.

(3) Commercially manufactured topical medications, which are over-the-counter or contain over-the-counter ingredients and do not meet the definition of “custom compound” as defined in R418.10108, dispensed by a pharmacy or provider other than a pharmacy, shall be dispensed in a 30-day supply. Reimbursement shall be at a maximum of the pharmacy or provider’s acquisition cost invoice, plus a single dispense fee. The single dispense fee shall be $8.50 and shall be billed with WC700-T.

Examples of these types of medications include, but are not limited to Dendracin, Lenzagel and Medrox.
Reimbursement for Biologicals, Durable Medical Equipment and Supplies

- R418.10103b

1. The carrier shall reimburse durable medical equipment (DME), supplies & biologicals at Medicare plus 5%. Biologicals that have NDC numbers shall be billed and reimbursed under R418.10912.

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, supply, or biological exceeding $35.00 is not listed in the fee schedule, or if the service is billed with a not otherwise specified code, the reimbursement shall be manufacturer’s invoice plus a percent mark up as follows:
(a) Invoice cost of $35.01 to $100.00 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%.
Billing for Durable Medical Equipment and Supplies

- R418.10913

(1) 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. Rental DME is considered a purchased equipment once the monthly rental allowance exceeds the purchase price or payment of 12 months rental, whichever comes first. (The exception to this is oxygen equipment.)

(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 payments shall not be made.

(c) The return of rental 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 miscellaneous supply, for example, a wig, shoes, or shoe modifications, shall be submitted on an invoice if the supplier is not listed as a health care professional.
Required Documentation for Reimbursement of Treatment for Chronic, Non–Cancer Pain with Opioids

- R418.101008a

- (1) In order to receive reimbursement for opioid treatment beyond 90 days, the physician seeking reimbursement shall submit a written report to the payer not later 90 days after the initial opioid prescription fill for chronic pain and every 90 days thereafter. The written report shall include all of the following:
(a) A review and analysis of the relevant prior medical history, including any consultations that have been obtained, and a review of data received from an automated prescription drug monitoring system in the treating jurisdiction, such as the Michigan Automated Prescription System (MAPS), for identification of past history of narcotic use and any concurrent prescriptions.
(b) A summary of conservative care rendered to the worker that focused on increased function and return to work.

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

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

(i) Overall treatment goals and functional progress.

(ii) Periodic urine drug screens.

(iii) A conscientious effort to reduce pain through the use of non-opioid medications, alternative non-pharmaceutical strategies or both.
(iv) Consideration of weaning the injured employee from opioid use.

(f) An opioid treatment agreement that has been signed by the worker and the attending physician. The agreement shall outline risks and benefits of opioid use, the conditions under which opioids will be prescribed, and the responsibilities of the prescribing physician and the worker.
(2) The provider may bill the additional services if required for compliance with these rules utilizing CPT procedure code 99215 for the initial 90 day report and all subsequent follow-up reports at 90 day intervals.

(3) Provider may bill $25.00 utilizing code MPS01 for accessing MAPS or other automated prescription drug monitoring program in the treating jurisdiction.
(4) A provider performing drug testing, drug screening, and drug confirmation testing shall use the appropriate CMS procedure codes G0477-G0483 listed in the HCPCS codebook, as adopted by reference in R418.10107.
Denial of Reimbursement for Prescribing & Dispensing Opioid Medications Used to Treat Chronic, Non–Cancer Pain

- R418.101008b

- Reimbursement for prescribing and dispensing opioid medications may be denied, pursuant to the act. Denial of reimbursement may occur if the physician reporting and treatment plan requirements as stated in R418.10008a are not met.

- Denial of reimbursement shall occur only after a reasonable period of time is provided for the weaning of the injured worker from the opioid medications, and alternative means of pain management have been offered.
WC–104C Application for Mediation or Hearing

- New box, petition to determine medical treatment.
- A carrier may file a WC–104C regarding one of their claimants/your patient.
- As the medical provider, you may be called by a mediator for response or further investigation.
- There will be an attempt to discuss and resolve medical treatment issues prior to moving the matter to the magistrate.
APPLICATION FOR MEDIATION OR HEARING — FORM C
Michigan Department of Licensing and Regulatory Affairs
Workers Compensation Agency
PO Box 30216, Lansing, MI 48909

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<th>Self-Insured Employer</th>
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Date(s) of Injury

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Check the box for each petition.

- [ ] Petition to stop weekly benefits
- [ ] Petition to fix fees
- [ ] Petition to resume
- [ ] Add Funds
- [ ] Petition to determine rights, e.g., dependency, AWW, etc.
- [ ] Petition to determine medical treatment
- [ ] Non-cooperation with vocational rehabilitation
- [ ] Redemption Only
- [ ] Other

Name of Petitioner

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Note: The form contains text boxes and options to fill in the details related to the application for mediation or hearing.
Laboratory Procedure codes and Maximum Allowable Payments

- R418.101503

- (4) A provider performing drug testing, drug screening, and drug confirmation testing shall use the appropriate CMS procedure codes G0477–G0483 listed in the HCPCS codebook.

- A maximum of one service unit per procedure code per date of service shall be billed with procedure codes G0477–G0483.

- Should not be using 80300–80304 (presumptive) or 80320–80377 (definitive).
Use only G0477–G0483

- **G0477**, Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), including sample validation when performed, per date of service.

- **G0478**, Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
**G0477-G0483 Continued**

- **G0479** Drug test(s), presumptive, any number of drug classes, any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDND, DESI, DART, GHPC, GC mass spectrometry, including sample validation when performed, per date of service.

- **G0480** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA), and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 1–7 drug class(es), including metabolite(s) if performed.
**G0481** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day 8–14 drug class(es), including metabolite(s) if performed.
G0482 Drug tests(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), include specimen validity testing, per day 15–21 drug class(es), including metabolite(s) if performed.
Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.
WC-750 Providers Request for Reconsideration Forms

- This is to be sent to the insurance company.
- Do not send it to the Workers’ Compensation Agency.
## PROVIDER'S REQUEST FOR RECONSIDERATION

### Michigan Department of Licensing and Regulatory Affairs

**Workers' Compensation Agency**

**Health Care Services**

PO Box 30019, Lansing, MI 48909

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<th>Employee Name</th>
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<table>
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<th>Address</th>
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<tbody>
<tr>
<td>City State ZIP</td>
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<th>Telephone Number</th>
<th>Claim Number</th>
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<th>District of Service</th>
<th>Charge</th>
<th>Payment</th>
<th>Requested Amount</th>
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**Reason for Reconsideration Brief Statement**

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<table>
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<tr>
<th>Documents Included:</th>
<th>WC-730</th>
<th>Requested Report</th>
<th>Office Notes</th>
<th>Bill</th>
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|                      |         |                  |              |      |

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*Protected Information to be used for identification purposes.*

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**LAWA** is an equal opportunity employer. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

**WC-780** (Rev. 213)
Voicemail Messages for Facilitators

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

- Kathy Witchell, Facilitator  517–284–8892  witchellk@michigan.gov
- Kris Kloc, HCS Analyst  517–284–8898  klock@michigan.gov
- David Campbell, Manager  517–284–8891  campbellk5@michigan.gov
- Insurance coverage:  517–284–8922
- Fax: 517–284–8899
- www.michigan.gov/wca
2017 Health Care Services Advisory Committee Meetings

- Wednesday, June 14, 2017
- Thursday, July 13, 2017
- Thursday, October 13, 2017
- All meetings are from 1:30 p.m. to 3:30 p.m.

- 2501 Woodlake Circle
- Okemos, MI 48864

The meeting site is accessible. Individuals attending the meeting are requested to refrain from using heavily scented personal care products in order to enhance accessibility for everyone. People with disabilities requiring additional services (such as materials in an alternative format) in order to participate in the meeting should contact Beth VanElls at 517-224-8902 at least 14 days before the event. LARA is an equal opportunity employer/program. These meetings follow the guideline of the Open Meetings Act.
The Workers’ Compensation Agency does not handle claims, pay bills, authorize treatment or issue checks.