

State of Michigan
Workers' Compensation Agency

Health Care Services Manual

(Fee Schedule)

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Department of
Labor & Economic Growth

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State of Michigan

Department of Labor & Economic Growth

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Health Care Services

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Health Care Services Manual

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Chapter 1

Overview and Guidelines

Introduction

The Health Care Services Policy Manual contains information regarding health services provided to treat an injury or illness causally related to employment for Michigan workers. The billing and payment information contained in this manual is based upon information found in the Health Care Services Rules

The manual is organized as follows:

General Information (Chapters 1-5) outlines the general policies and procedures applicable to all providers and payers.

Coding and Fee Information (Chapters 6-13) contains a chapter for each category of medical service. The policies, procedures and the maximum allowable payment (MAP) are listed in each category of service.

Ancillary Services (Chapter 14) contains coding and payment information for services described with coding from Medicare's National Level II Code book.

Hospital Services (Chapter 15) contains information regarding payment for facility services and the hospital's maximum payment ratios.

Agency Information (Chapter 16) contains examples of forms and agency contact numbers.

The Health Care Services Manual was designed to be as user friendly as possible. Suggestions for further improvements or to report any possible errors, please contact:

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Copyright Notice

Procedure codes and descriptors found in this manual are from the latest edition of "Physicians' Current Procedural Terminology (CPT®)" published by the American Medical Association (AMA). All rights reserved. Abbreviated descriptors are noted in this manual. **For a complete description of the procedure codes, refer to "Physicians' Current Procedural Terminology (CPT®)."**

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No fee schedules, relative value units (RVU's) or conversion factors are included in the CPT® book. The AMA assumes no responsibility for the consequences attributed to or related to any use or interpretation of any information contained or not contained in this product.

The AMA does not directly or indirectly practice medicine nor dispense medical services. The AMA assumes no liability for the data contained herein.

Providers Covered by the Rules

All providers of health care services must be licensed, registered or certified as defined in the Michigan Public Health Code, Act 368 of 1978, (Articles 1,7,15,19, and Excerpts from Article 5) as amended.

Evaluation and management services and minor surgical procedures performed by nurse practitioners and physician assistants are billed with modifiers. Reimbursement is adjusted to 85% of the MAP amount or the practitioner's usual and customary charge, whichever is less. Service level adjustment factors are as follows:

Nurse Practitioner	-AK	0.85
Physician's Assistant	-AU	0.85

Mental health therapeutic services are reimbursed adjusted according to a service level adjustment factor. Services billed by the following practitioners must be identified by the listed modifiers and will be adjusted to 85% or 64%, depending on the service provider noted by the modifier. No adjustment is necessary for diagnostic testing procedures performed.

Certified Social Worker	-AJ	0.85
Limited License Psychologist	-AL	0.85
Licensed Marriage & Family Therapist	-MF	0.85
Licensed Professional Counselor	-LC	0.85
Limited Licensed Counselor	-CS	0.64
Limited Licensed Marriage & Family Therapist	-ML	0.64

Services Listed in the Manual

The state of Michigan workers' compensation schedule of maximum allowable payments is listed in this manual. Chapters 6-13 contain the policy and procedures unique to that category and the services are listed in numeric order according to CPT® coding. The manual lists the CPT® code, the RVU, the MAP and the follow-up days for surgical procedures. **Except where otherwise noted in this manual, billing instructions listed in the "Physicians Current Procedural Terminology (CPT®)" shall apply.**

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Maximum Allowable Payment (MAP) Amounts

The maximum allowable payments in this manual are based upon the Health Care Financing Administration's (HCFA) resource-based relative value scale (RBRVS). RBRVS attempts to ensure the fees are based on the resources used to provide each service described by CPT[®] procedural coding. Relative values are derived based on the work involved in providing each service (practice expense involved including office expenses and malpractice insurance expense), and applying specific geographical indices, (GPCI), to determine the relative value unit (RVU). Michigan workers' compensation is applying the following GPCI resulting from a meld using 60% of the Detroit area GPCI and 40% of the rest of the state's GPCI.

Work	1.0246
Practice Expense	.998
Malpractice	2.2712

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

$$\text{(Work RVU's x 1.0246) + (Practice Expense RVU's x .998) + (Malpractice RVU's x 2.2712) = RVU}$$

Most MAP amounts in Chapters 6-13 (except for anesthesia services) are pre-calculated and listed as dollar amounts. The MAP amounts were determined by multiplying the **RVU times the conversion factor**. The conversion factor for the CPT[®] procedure codes is found in R 418.101002 of the Health Care Services rules

Determining Payment

The MAP amounts listed in this manual represent the maximum allowable payments that a provider can be paid for rendering services under the state of Michigan Workers' Compensation Act. When a provider's charge is lower than the MAP amount, or if a provider has a contractual agreement with the carrier to accept discounts for lower fees, payment is made at the lower amount.

Workers' Compensation laws are state specific and these rules and fees apply to providers licensed to practice in Michigan. A provider licensed by the state of Michigan billing a carrier for a service must accept the maximum allowable payment and shall not balance bill the worker (Refer to R 418.10105).

By Report (BR) Services

When a CPT[®] code does not have an assigned numeric RVU, the procedure will be listed as BR (by report). A provider who submits a claim for a BR service(s) should include all pertinent documentation, including an adequate definition or description of the nature and extent of the service and the time, effort, and equipment necessary to

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provide the service. A BR procedure is reimbursed at the provider's usual and customary charge or reasonable amount determined by the carrier, whichever is less.

Codes Not Listed in the Manual

Every effort has been made to include all of the CPT[®] codes and the assigned relative value units in this manual. Inclusion of the CPT[®] code in the manual does not guarantee compensability of the service. The carrier is responsible for reviewing the service(s) to determine if the treatment is related to the work injury or illness.

When a procedure code is not listed in the manual but is listed in either the CPT[®] book or Medicare's National Level II HCPCS for the date of service, the code shall be billed and reimbursed at the provider's usual and customary charge or reasonable amount, whichever is less.

Independent Medical Evaluations (IME's)

A carrier or employee may request an independent medical evaluation (IME). A practitioner other than the treating practitioner must do an independent medical examination. The IME is exempt from the Health Care Services Rules for cost containment and payment is determined on a contractual basis. The carrier and provider should address how diagnostic testing will be reimbursed in the contractual agreement.

A carrier may request an examination to determine the medical aspects of the case. This examination would be considered a confirmatory consult. The confirmatory consult is billed with procedure codes 99271-99275 and paid in accord with the fees listed in the Evaluation and Management Section of this manual.

Claim Filing Limitation

A provider should promptly submit their charges to the carrier to expedite claims processing. The carrier is not required to reimburse claims submitted after **one year from the date of service except for:**

**Litigated cases
When subrogation has occurred**

Do not submit claim forms or requests for reconsideration to workers' compensation, as the agency does not pay or review bills. The State of Michigan Workers' Compensation Health Care Services Rules discusses this information in R 418.10113 and R 418.10901(3).

Rehabilitation Nurse or Nurse Case Managers

When a carrier assigns a nurse case-manager or a rehabilitation nurse to a worker's

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compensation case and the nurse accompanies the patient to physician-office visits, the physician may bill RN001. The carrier will then reimburse the physician for RN001, a work-comp code specific for Michigan, in addition to the office visit, and be paid for the additional service. If the patient is seen during the global surgery period and is accompanied by the nurse case manager, procedure RN001 is payable even though the routine non-complicated office visit is included in the global period for the surgical procedure. The fee for RN001 is listed in R 418.101502.

Chapter 2

General Policy

This chapter contains the general information regarding medical services provided to injured workers in the state of Michigan.

Employee Responsibilities

An employee receiving an injury or illness during the course of employment must report the injury to his employer. The employer may direct care for the injured worker for the first 10 days. Following the initial 10 days of care, **the worker may treat with a physician of his or her own choice as long as the worker notifies the carrier of their choice.** If an employee receives a bill from a health care provider for a covered work injury, the employee should submit the bill to the employer or if known the worker's compensation carrier for payment.

Employer Responsibilities

The Workers' Disability Compensation Act outlines in Section 315 that an employer must furnish or cause to be furnished all necessary and reasonable medical, surgical, and hospital services and medicines, other attendance or treatment recognized as legal, for an employee receiving an injury or illness in the course of employment. The employer has the right to direct the employee to a provider of the employer's choice for the first 10 days of care commencing for the injury or illness and should **report the injury to their workers' compensation carrier.**

The insured employer must promptly file the Form 100, "Employer's Basic Report of Injury" reporting cases when the injury results in 7 or more days of disability, specific loss or death. The insured employer must inform the provider of the name and address of its insurer or the designated agent of the insurer to whom the health care bills should be sent. If the insured employer receives a bill, the employer shall promptly send the provider's bill and documentation to the carrier.

Provider Responsibilities

A provider shall promptly bill the carrier on the proper claim form and attach any documentation required by the Health Care Services Rules. When a provider bills the carrier and receives **no response in 30 days, the provider should send a second copy of the bill to the carrier and add a 3% late fee.**

The provider may file for an "Application for Mediation and Hearing," (104B) for unresolved claims (See Part 13 of the Rules and Chapter 4, pg. 4.5 of this manual) when:

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The provider has sent 2 bills to the carrier and waited a total of 60 days for a case that has not been disputed.

Payment was not made in accord with the maximum payments established by the Health Care Services Rules, or the carrier has disputed utilization of the overall services. If the issue(s) are not resolved through the reconsideration process, the provider may file a 104B.

When the worker contests a carrier's dispute and the case becomes contested or litigated (worker files 104A to the agency for a hearing). **The provider should then file a 104B to be added as an intervening party to the carrier/worker dispute.**

Note: If the worker has not contested the carrier's denial, then the worker or his health insurance is responsible for services disputed as not work-related.

Carrier Responsibilities

When the carrier receives notice of an injury or illness, the carrier:

- ◆ Establishes a case record. When the carrier receives a bill from the provider and does not have an injury report on file from the employer, the carrier should follow-up with the employer. The carrier will also investigate a case if notified by the provider with form 117 H, "Provider's Report of Claim."
- ◆ Determines compensability.
- ◆ Reviews medical bills for payment. **The carrier is required to pay the medical services within 30 days of receipt of a provider's properly submitted bill or must pay the provider a self-assessed 3% late fee applied to the MAP.**
- ◆ Notifies the provider of their decision to pay, adjust or reject a medical provider's bill on a form entitled "**The Carrier's Explanation of Benefits.**"
 - The Health Care Services Division of the workers' compensation agency determines the format for this form.
 - Changes to the format may not be made without approval from HCSD.
 - A copy must be sent to the injured worker and the provider.
 - A copy of the form, WCA-739 (Rev 02-01) is located in Chapter 16.

Certification of a Carrier's Professional Review Program

The State of Michigan Workers' Disability Compensation Act does not mandate managed care or prior authorization for reimbursement of medical services. The carrier is required to review the medical services provided to ensure that the services are reasonable and related to the work injury or illness (refer to Part I, R 418.10101, Scope of the Health Care Services Rules).

- ◆ Carrier will submit form WCA-590 "**Application for Certification of Professional Review**" and attach a **current methodology** detailing how their

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company performs review. A copy of the form is located in this manual in Chapter 16. The methodology is submitted every 3 years or whenever changes occur.

- If a current methodology is on file with health care services for the carrier or the reviewing entity, then only the application need be submitted. The carrier should contact the agency to see if the methodology on file is current.
- The carrier is required to re-submit an “Application for Certification of Professional Review” 6 months prior to the expiration date of the certification.
- The carrier must re-submit when any of the following change:
 1. Service Company
 2. Review Company.
 3. Substantial change in methodology (must also include the new methodology).
- ◆ Certification of the carrier’s review program is generally granted for a period of 3 years.
- ◆ A copy of the certification is sent to the carrier, Service Company and Review Company when appropriate.

Utilization Review

The carrier’s professional review program consists of both technical review and professional review. Technical review is outlined in R 418.101203 and professional review is discussed in R 418.101204.

1. Technical Review

- ◆ Frequently done as a computer review designed to edit claims for workers’ compensation in Michigan.
- ◆ Carrier is responsible for determining accuracy of coding and edits performed by the computer software. The Carrier’s Explanation of Benefits shall detail reasons for recoding any procedure in accord with Part 13 of the rules.
- ◆ Determine that the amount billed for a procedure does not exceed the maximum allowable payment established by the rules. The carrier is responsible for determining accuracy of the technical computer review when performed. Include the name of the software program used in the technical review process within the methodology.
- ◆ Specifically identify what bills and case records the carrier refers for professional health care review according to R 418.101205.

2. Professional Review Program

- ◆ Must comply with R 418.101205, scope of professional health care review.
- ◆ Document the process ensuring confidentiality of worker-specific and provider-specific information.
- ◆ Utilization review will look at coding accuracy and compensability issues.
- ◆ Determines medical necessity and appropriateness of services.

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- ◆ Medical claims review is generally retrospective as Michigan law does not mandate managed care, and is performed strictly for purposes of reimbursement.
- ◆ Most frequently performed by a registered nurse or other licensed health care professional with suitable expertise in occupational injury or disease processes and the billing process.
- ◆ Licensed health care professionals must develop criteria used in the carrier's review process.
- ◆ Submit license documentation for each professional, including full name, professional license number, state of issue, date of expiration and any restrictions on current licensure. Include the same documentation for the medical/clinical director supporting reviewers.

Note: Trained non-clinical staff may be used in the application of these criteria, when their duties have oversight by a licensed health professional.

3. Peer Review

- ◆ May be performed when the claim is initially submitted or when any outstanding issues cannot be mutually resolved through the written reconsideration process.
- ◆ The carrier may utilize peer review to support decisions made in the utilization review process when the carrier and the provider cannot mutually resolve the issues.
- ◆ Generally performed by a doctor of medicine, doctor of osteopathy, chiropractic physician, or a physical therapist having the same clinical licensure as the treating provider whose services are being reviewed.
- ◆ The methodology utilized by a carrier for professional review shall include a list of all peer reviewers with their specialty and licensure information.

4. Reconsiderations/Appeals (Outlined in Part 13 of the Rules)

- ◆ Carrier must pay a properly submitted bill in 30 days or pay the provider a 3% late fee and the notice of payment is sent on the Carrier's Explanation of Benefits.
- ◆ If the provider disagrees with the utilization decision or the payment is not made in accord with the rules, then the provider submits a written request for reconsideration.
- ◆ If the carrier does not respond within 30 days to the provider's request for reconsideration or does not mutually resolve the outstanding issue, then the provider should file an "Application for Mediation and Hearing" on the original orange form, sending a copy to the carrier.

Annual Medical Payment Report

A carrier is also required to submit an "**Annual Medical Payment Report**" to health care services, documenting the number of medical only cases, the number of wage loss

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cases and the total dollars spent for health care for those cases. The reporting period will begin each year on January 1 and end each year on December 31. A copy of the form is located in Chapter 16. The Annual Medical Payment Report is due February 28 for the preceding calendar year and should include:

- ◆ Carrier Information
- ◆ Signature, address and telephone number of person responsible for completion of the form.
- ◆ The number of Medical-Only Cases and the total dollars spent for medical services in that year. Medical-only is defined as those cases where no indemnity was paid.

NOTE: Refer to the definition of a case in the Health Care Services Rules. Each case will generally have multiple bills. Do not count each bill as a case.

- ◆ The number of Wage-Loss/Indemnity Cases and the total dollars spent for medical services in that year. Wage-loss is defined as those cases in which the carrier paid wage-loss replacement. For the purposes of this Annual Medical Payment Report, once wage-loss benefits are paid, the case will always be reported as wage-loss.
- ◆ **Report only medical expenses.** Do **not** include payments for:
 - Indemnity
 - Mileage reimbursements
 - Vocational rehabilitation
 - Rehabilitation case management
 - Independent medical evaluation(s)

Service Companies and Insurance Companies will report as follows:

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

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

- ◆ **Self-Administered Employers or Self-Administered Group Funds**
 - Do not have a service company and are responsible for submitting their own reports.

- ◆ **Insurance Companies**

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- May submit one consolidated report for all insurance companies within their group. When more than one company is included in the report, a listing of all the companies included must be attached.

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

Required Documentation

Providers are required to submit documentation for the following: (See R 418.10901)

- , The initial visit
- , A progress report if still treating after 60 days
- , Evaluation for physical treatment (PT, OT, CMT, OMT)
- , A progress report every 30 days for physical treatment
- , An operative report or office note (if done in the office) for a surgical procedure
- , A consultation
- , A written report is required whenever the professional component of an x-ray is billed
- , The anesthesia record for anesthesia services
- , A functional capacity or work evaluation
- , When billing a BR (By Report) service, a description of the service is required
- , Whenever a modifier is used to describe unusual circumstances
- , Whenever the procedure code descriptors includes a written report

Medical Records. The provider’s medical record is the basis for determining necessity and for substantiating the service(s) rendered; therefore, the carrier may request the record. Medical records must be legible and include the information pertaining to:

1. The patient’s history and physical examination appropriate to the level of service indicated by the presenting injury or illness;
2. Operative reports, test results and consultation reports;
3. Progress, clinical or office notes that reflect subjective complaints of the patient, objective findings of the practitioner, assessment of the problem(s), and plan(s) or recommendation(s); and,
4. Disability, work restrictions, and length of time, if applicable.

Copies of Records and Reports

A carrier or a carrier’s agent, a worker or a worker’s agent may request additional case records other than those required by the Rules (See Rule 113 and Rule 114). Providers

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are entitled to charge for the cost of copying the records. **Only those records for a specific date of injury are covered under the Health Care Services Rules.** Those records are reimbursed at 25 cents per page plus the actual cost of mailing. In addition, an administration charge shall be paid for the staff's time to retrieve and copy the record and is paid as follows:

0-30 minutes	\$3.50
31-60 minutes	\$7.00
Each additional 30-minute increment	\$3.50

The copying and handling charge applies to all reports and records **except** the original copy required under the provision of Rule 113 and all other reports required by the rules. The party requesting the records pays the copying charge.

For records other than those applying to the specific date of injury (case record) the provider may bill their usual and customary charge.

Chapter 3

Billing Policy

This chapter contains policies and procedures for providers submitting claims and for payers reviewing and processing those claims. Specific instructions for completing claim forms are found in Chapter 5. Additional billing information is contained in Chapters 6-13 of this document. Each section contains billing information specific to the category of services listed in that section.

Billing Information

Providers must submit charges to the carriers on the appropriate health insurance claim form. Documentation required by the rules must be legible. A carrier must pay only licensed providers and facilities. When a provider treats an injured worker, the claim is sent to the workers' compensation carrier. The provider shall be paid the maximum allowable payment (MAP) allowed by the Health Care Services Rules for services to treat a covered work injury or illness.

The following claim forms are adopted by the Health Care Services Rules for billing medical services:

- , CMS-1500 claim form for practitioner billing
- , UB-92 claim form to bill for facility services
- , Universal pharmacy claim form or an invoice for billing outpatient pharmacy services
- , American Dental claim form for dental services

Note: A hospital owned occupational or industrial clinic is considered a practitioner service.

If the carrier or employer makes the worker's appointment and the employer or carrier fails to cancel the appointment within 72 hours, the provider may bill for a missed appointment (**e.g., IME or confirmatory consult**) using procedure code 99199.

Balance Billing

According to Michigan law, a provider may not bill the employee for any amount of the charge for health care services provided for the treatment of a covered injury or illness.

A provider may not balance bill (refer to Rule 105):

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

Chapter 3 Billing Policy

When there are balances due to the utilization review, the provider may send a request for **reconsideration to the carrier**, and if unresolved, file a request for mediation (unless the MAP was paid by the carrier).

Procedure Codes

Procedure codes from *Physician's Current Procedural Terminology (CPT®)* and *Medicare's National Level Codes (HCPCS)* as adopted by reference in the Health Care Services Rules, 418.10107, are used to report medical services. CPT coding is used primarily for services, and HCPCS codes are used to report supplies and durable medical equipment as well as ancillary services such as dental services, hearing and vision services. The CPT® procedure codes and MAP amounts are listed in fee tables contained in this manual. Services not listed in the schedule will be considered as "by report" (BR).

Procedure codes and billing instructions are adopted from *CPT®*, however, reimbursement is determined by the carrier based upon their utilization review using consistent medical standards. A carrier is only required to reimburse necessary and reasonable medical services causally related to the work injury or illness.

Administered, Injectable Pharmaceuticals and Supplies Dispensed in the Practitioner's Office

When an injectable drug is administered along with an evaluation and management service, the drug is billed and identified with CPT® 99070 or the appropriate J Code from HCPCS, and the NDC number. The office notes must identify the drug administered. A therapeutic injection administration fee is not paid in conjunction with an office visit. The drug is reimbursed at average wholesale price (AWP).

When a physician dispenses a prescription drug from his office, the drug is reimbursed at AWP plus a \$4 dispense fee. The dispense fee cannot be paid more often than every 10 days for **each** prescription drug. A dispense fee is not paid when over-the-counter (OTC) medications are dispensed.

Supplies dispensed from the practitioner's office are billed with code 99070, or the appropriate HCPCS code, and a report describing the service must be attached to the bill. Supplies are reimbursed at AWP + not more than 50%.

Pharmacy Services

Outpatient pharmacies and providers dispensing prescription drugs or medical supplies must have oral or written confirmation from the carrier that the services are for a covered work injury along with instructions on where the bill is to be sent. Until the carrier gives such direction, those providers are not bound by the Health Care Services Rules.

Chapter 3 Billing Policy

An outpatient or mail order pharmacy must submit charges for prescription medications on either a universal pharmacy claim form or an invoice statement.

Charges for prescription drugs dispensed from the doctor's office or a health care organization shall be submitted on a CMS 1500.

The following apply to pharmacy services:

- , Unless the prescription is labeled "Dispense as Written" (DAW), the generic drug should be dispensed.
- , The reimbursement for prescription drugs is the average wholesale price (AWP) plus a **\$4 dispense fee** for each prescription drug. **Not more than one dispense fee shall be paid for each drug every 10 days.**
- , **A bill for a prescription drug shall include:**
 1. Name of the drug and the manufacturer's name
 2. Strength of the drug
 3. Quantity and the dosage of the drug
 4. Name and address of the pharmacy or health care organization
 5. Prescription number when dispensed by a pharmacy
 6. Date dispensed
 7. Who prescribed the medication
 8. Patient name, address and social security number
 9. National drug code as listed in Red Book

Supplies and durable medical equipment are reimbursed at AWP + not more than 50%. **The L-code procedures have fees established and are printed in the rules and published in this manual.**

Modifiers

A modifier is a two-digit number added to a CPT[®] procedure code to explain a specific set of circumstances. A two-letter alpha code may also be used to describe the practitioner providing the service. For certain services and circumstances the use of a modifier is required. The use of a modifier does not guarantee additional payment to the provider.

Submitting Claims for Payment

Providers are responsible for submitting claim forms to the carrier for payment. A carrier is defined as an insurance company or a self-insured employer or self-insured group fund or one of the funds specified in the Act. **When a provider is unable to get**

Chapter 3 Billing Policy

carrier information from the employer, contact the employer compliance division at (517) 322-1885 with the following information:

- , Employer name and address
- , Date of injury or date of first symptoms for reported illness

A provider can also obtain carrier information from the agency website: www.michigan.gov/wca and clicking on the insurance coverage tab at the top of the page and entering the employer information. **Carrier information found on this page reflects CURRENT coverage only. Dates of injury prior to the date of look up may be identified with a different carrier coverage. Please call (517) 322-1885 to verify coverage for prior dates of injury.**

Collecting Medical Fees

Health care services does not review claims for payment or reimburse medical providers. The carrier (insurance companies, self-insured employers or self-insured group funds, or one of the funds specified in the Act) is responsible for claims management and payment medical services as well as wage-loss benefits. Contact the carrier to determine the status of the claim.

Chapter 4

Payment Policy

This chapter contains policies and procedures governing the payment of workers' compensation claims for medical services. The information herein will serve as a guide to payers when determining appropriate payment for medical claims.

General Payment Policy

The carrier is required to reimburse for all medically necessary and reasonable health services in accord with Section 315 of the Workers' Disability Compensation Act. The medical services must be performed by licensed, registered or certified health care providers and services must be provided to the extent that licensure, registration or certification law allows.

The amount paid will be the Maximum Allowable Payment (MAP), in accord with the rules, or the provider's usual and customary charge, whichever is less (this applies to modified services as well). Payment will be made only for actual services rendered for the covered work injury or illness.

Services Rendered by Providers Outside the State of Michigan.

When practitioners or facilities in states other than Michigan render services for Michigan workers, the provider may or may not accept the MAP made in accord with the Michigan fees. If an out-of-state provider requests reconsideration of payment, the carrier may attempt to negotiate the fee. However, if the provider refuses to negotiate fees, the carrier must reimburse the provider's charge. The worker is not responsible for any unpaid balances of the provider's charges and should be instructed to send any bills received to the carrier for resolution.

Workers' Compensation Laws are State-Specific

Workers' compensation laws in Michigan apply only to Michigan workers. A federal employee or an employee working for a company located outside of the state of Michigan would not be covered under Michigan law. A Michigan provider may only access the hearing system for workers' compensation for medical services rendered to Michigan workers.

When a provider treats a federal employee or a worker injured in another state's jurisdiction, the health services will be reimbursed in accord with either federal labor laws or those of the specific state where the employee worked.

Chapter 4 Payment Policy

Claims Review and Reduction

A carrier must ensure that their technical review programs (data software) result in correct payments in accord with the maximum allowable payment (MAP) amounts outlined in the rules.

A carrier shall perform utilization review for medical services to ensure that those services are necessary, reasonable, and related to the work injury or illness. Licensed, registered or certified health care professionals must perform utilization review, and when necessary, peer review of medical services shall be completed by the carrier to support their utilization decisions.

The carrier is responsible for reviewing medical claims for compensability and determining the services are necessary and reasonable. The carrier is required to perform professional review of the medical services whenever payments on a case exceed \$5,000.00, there is an inpatient admission, or on any case deemed appropriate by the carrier.

Services Not Substantiated by Documentation

In a case where the reviewer cannot find evidence in the notes or operative report that the service was performed, the charge for that service may be denied. The EOB must indicate the reason for the denial.

Services Not Accurately Coded

When a service billed is supported by documentation, but the code selected by the provider is not the most accurate code available to describe that service, the disputed amount shall be limited to the amount of the difference between the MAP of the code billed, and the MAP of the code recommended by the reviewer. Therefore, the reviewer must not deny payment for the service, but recommend a payment based on the more accurate code.

The carrier may not take the position that the provider's acceptance of payment constitutes agreement with the decision. The provider has the right to dispute the decision requesting reconsideration and a hearing if not resolved through reconsideration.

Examples of Common Coding Errors Include:

- , An office visit is coded at a higher level than substantiated by the medical record
- , Two x-ray codes are billed when a single x-ray code describes the number of views taken

Chapter 4 Payment Policy

A debridement code is billed with another code whose descriptor includes the debridement

Providers can reduce the frequency of services being re-coded by following guidelines within the CPT® book for correct coding and guidelines found in the Health Care Services Rules.

Determining Payment for “By Report” (BR) Services

Supplies and durable medical equipment are “by report” (BR) and require a description of the service when billed. Reimbursement for the supplies and durable medical equipment are AWP + not more than 50%.

Ancillary services (dental, hearing, vision, and home health services) and services without an assigned RVU are reimbursed at a reasonable amount or the provider’s usual and customary charge, whichever is less. **“Reasonable” is defined for the purposes of reimbursement as “a payment based upon the amount generally paid in the state for a particular procedure code using data available from the provider, the carrier, or the agency.”**

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

Multiple Patient Visits

Unless substantiated by medical necessity, only one patient visit per day, per provider may be paid. Generally when a provider sees a patient twice in one day for necessary services, the values of the visits are added together and a higher level of service is billed.

Separate Procedures

Certain services carry the designation “**separate procedure**” in their CPT® descriptor. These are services that are commonly performed as an integral part of a total service and, as such, must not be paid as a separate procedure. When a “separate procedure” is performed independently of, and not immediately related to other services, it may be billed and paid.

Total Procedures Billed Separately

When two separate providers are submitting separate claims for certain diagnostic procedures (neurological testing, radiology and pathology procedures, etc.) the services are identified professional and technical portions of the service. When this occurs, the carrier will pay according to the professional and technical components.

Chapter 4 Payment Policy

The billing procedures in Chapters 6-13 stipulate that providers must indicate on the claim form that the technical and professional components were performed separately by adding a modifier to the CPT code. Modifier -26 indicates that only the professional component was performed; modifier -TC indicates that only the technical component was performed.

Completion of the Explanation of Benefits (EOB) Form

The EOB form must be sent to the provider with a copy sent to the worker. The carrier shall ensure that the following information is included on the EOB:

- , The provider charge, reimbursement allowed, and reason for the reduction. The carrier may use a “reason-code” but must clearly provide a written explanation.
- , The EOB should tell the provider how to request reconsideration and what information is needed.
- , If the check is not sent with the EOB there must be information included so that the provider can relate specific payment to the applicable services (claimant, procedure, and date of service).

Disputed Payments

When a provider is dissatisfied with a payer’s reduction or denial of a charge for a work related medical service, the provider may submit to the carrier a **written request for reconsideration *within 60 days of receipt of payment***. The request must include a detailed explanation for the disagreement, and documentation to substantiate the charge/service in question. Providers may not dispute a payment because of dissatisfaction with a MAP amount. Refer to Part 13 of the Rules for resolving differences. When the provider is dissatisfied with payments resulting from contractual agreements, the provider must refer to that agreement and not enter into the hearing system for workers’ compensation.

Upon receipt of a request for reconsideration, the payer must review and re-evaluate the original bill and accompanying documentation, using its own medical consultant or peer review if necessary, and respond to the provider within 30 days of the date of receipt. The payer’s response to the provider must explain the reason(s) behind the decision and cite the specific policy or rule upon which the adjustment was made.

Mediation Applications (104B’s)

Medical providers, insurance companies, and self-insured employers may request a mediation hearing with workers’ compensation by submitting the “Application for Mediation and Hearing” form (104B). A carrier may request a hearing to recover overpayments (refer to Rule 119); however, providers of health care services most frequently request hearings when those services have not been correctly paid. An

Chapter 4 Payment Policy

injured worker may not use the 104B to request a hearing or contest his case. The injured worker with questions should be instructed to call customer service at (888) 396-5041 selecting #1 on each menu, or (517) 322-1980.

A Provider's Reasons for Requesting Mediation Hearings:

- , No response to the provider's bill.
- , Payment dispute unresolved though the reconsideration process.
- , A provider **should** file a 104B whenever he learns that the workers' case is contested (the carrier denied compensability and the worker filed a 104A form).

Note: When an injured worker does not dispute the carrier's denial of a case by submitting a 104A to the agency, the worker or his health insurance is responsible for the health services. A worker should not be turned over to collections if there is a pending worker's compensation claim that has not been resolved by the magistrate.

The requesting party submits the original (orange) form to the agency and sends a copy to the carrier or provider as appropriate. **The 104B form may be obtained from workers' compensation.** Documentation is not sent with the application, but is taken to the mediation site.

Ordering Forms

Workers' Compensation forms, including 104B forms, are obtained from the agency. You may order forms by one of the following methods:

- < Mail request to Claims Division, WCA, PO Box 30016, Lansing MI 48909
- < Email to winfo@michigan.gov
- < Request by Fax (517) 322-1808
- < Call (888) 396-5041 and follow the prompts for forms

All requests should include a contact name, phone number, company name, street address, city, state, zip code, the name of the requested form, and quantity.

Chapter 5

Completing and Submitting Claims

This chapter contains specific instructions for completing medical claim forms. Failure to provide the information in the manner requested herein may result in claims being returned for correction, additional information, or denial.

Claims Prepared by a Billing Service

Claims prepared for a provider by a billing service must comply with all applicable sections of this manual.

Completing the 1500 Form for Practitioner Billing

The CMS-1500 (Formerly known as HCFA-1500) is the standard claim form used for practitioner services. The instructions listed below indicate the information required to process practitioner claims for workers' compensation cases. The CMS-1500 (12-90) is the most recent format and the preferred form.

Note: Radiologists (billing technical services only), pathologists, and ambulance services are not required to enter a diagnostic code.

CMS-1500 (12-90) Claim Form Elements 1 through 33

1. Mark other
- 1a. Patient's social security number
2. Name of the patient
3. Patient's sex and date of birth
4. Name of the workers' compensation carrier
5. Patient's complete address omitting the telephone number
6. Omit
7. Carrier address. Omit the telephone number
8. Omit
9. Enter the employer's name
- 9a. Omit
- 9b. Omit
- 9c. Omit
- 9d. Omit
10. Mark the appropriate boxes
11. Omit
- 11a. Omit
- 11b. Omit
- 11c. Omit
- 11d. Omit

Chapter 5 Completing and Submitting Claims

12. Omit
13. Omit
14. Date of the work-related accident or the first symptoms of work-related illness
15. Complete if appropriate and if known
16. Enter the month, day, and year if applicable
17. Name of the referring physician
- 17a. Omit
18. Date if applicable
19. Omit (Optional use-may list NDC's for J codes)
20. Mark appropriate box
21. Diagnostic numeric or alpha code
22. Omit
23. Omit
- 24a. Date for each service, "from/to" dates may be utilized
- 24b. Place of service code
- 24c. Type of service code
- 24d. Enter the procedure code and modifier if appropriate. Attach documentation to explain unusual circumstances
- 24e. Related diagnosis number(s) 1, 2, 3, 4 as appropriate
- 24f. Charge for each procedure billed
- 24g. Complete this column for multiple units or total minutes for anesthesia services
- 24h. Enter "DB" for duplicate bill with the date billed
- 24i. Omit
- 24j. Omit
- 24k. Omit
25. Enter the provider's FEIN
26. Enter the patient's account or case number
27. Omit
28. Enter the total charges
29. Omit
30. Omit
31. Enter the date of the bill
32. Complete if applicable
33. Practitioner's name, license, registration or certification number, address, zip code, and telephone number

Site of Service Codes Place in element 24b on the CMS-1500 (12-90)

NOTE: Place-of-Service codes are located in the front of the CPT book. A complete listing of the following codes can be found at the CMS Web site <http://cms.hhs.gov/states/posdata.pdf>.

- 11 - Office or clinic.
- 12 - Patient home.
- 21 - Inpatient hospital.
- 22 - Outpatient hospital.
- 23 - Emergency room - hospital.
- 24 - Ambulatory Surgical Center (Free-Standing Outpatient Surgical Center).

Chapter 5 Completing and Submitting Claims

- 31 - Skilled nursing facility.
- 32 - Nursing home/nursing facility.
- 33 - Custodial care Facility.
- 34 - Hospice.
- 41 - Ambulance (land).
- 42 - Ambulance (air or water).
- 51 - Inpatient psychiatric facility.
- 52 - Day care facility (psychiatric facility/part hospital).
- 53 - Community mental health.
- 56 - Psychiatric residential facility.
- 81 - Independent laboratory.
- 99 - Other locations (other unlisted facility).

Type of service codes Place in element 24c on the CMS-1500 (12-90). **A complete listing of the following codes can be found at the CMS Web site**

[Http://www.cms.hhs.gov/manuals/pm_trans/R1783B3.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R1783B3.pdf)

- 1 - Medical care.
- 2 - Surgery.
- 3 - Consultation.
- 4 - Diagnostic x-ray.
- 5 - Diagnostic laboratory.
- 6 - Radiation therapy.
- 7 - Anesthesia.
- 8 - Assistance at surgery.
- 9 - Other medical items or service.
- 0- Whole blood.
- A - Used durable medical equipment.
- F - Ambulatory surgery center.
- H - Hospice.
- L- ESRD supplies in the home.
- W- Physical Therapy

American Dental Association Claim Form

In the top two boxes:

Left. Mark appropriate box, pre-treatment estimate or statement of actual services.

Right. Enter the workers' compensation carrier name and address.

Item 1. Patient Name, First, M.I., Last

Item 2. Mark "self."

Item 3. Enter the sex of the patient.

Item 4. Enter patient's birth date (MMDDYYYY).

Item 5. Omit.

Item 6. Enter the patient's complete mailing address.

Item 7. Enter the patient's social security number.

Item 8. Omit.

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Item 9. Enter the employer's name.

Item 10. Enter the employer's complete mailing address.

Item 11. Omit.

Item 12-a. Omit.

Item 12-b. Omit.

Item 13. Omit.

Item 14-a. Omit.

Item 14-b. Omit.

Item 14-c. Omit.

Item 15. Omit.

Item 16. Enter the name of the dentist or dental organization.

Item 17. Enter the complete address of the dentist or the dental-organization.

Item 18. Enter the social security number or FEIN for the dental provider.

Item 19. Enter the dentist's license number.

Item 20. Enter the dentist's telephone number.

Item 21. Enter the first visit for the current series of treatment.

Item 22. Mark appropriate box for place of treatment.

Item 23. Indicate if x-rays are enclosed and how many.

Item 24-30. Mark appropriate boxes. Enter the date of injury in Item 24.

Item 31. Enter the tooth number, a description of the service, and the date of service, the procedure number, and the fee.

Item 32. Indicate with an "x" any missing teeth. Add remarks for unusual services. Include any dental disorders that existed before the date of injury.

Facility Billing

Licensed facilities are to submit facility charges on the UB-92 claim form in accord with the billing instructions provided in the UB-92 billing manual published by the Michigan Health and Hospital Association. The workers' compensation carrier is responsible for ensuring that the form is properly completed prior to payment. **A copy of the UB-92 billing manual can be obtained by contacting:**

Michigan Health & Hospital Association
UB-92 Manual Subscription
6215 W. St. Joseph Hwy.
Lansing MI 48917
(517) 323-3443

Hospitals must submit charges for practitioner services on the 1500 claim form. Examples of practitioner services billed by the hospital are:

- , Anesthesiologists or nurse practitioners
- , Radiologists
- , Hospital-owned physician practices
- , Hospital-owned occupational or industrial clinic

Chapter 6

Evaluation and Management

This section stipulates only those policies and procedures that are unique to Evaluation and Management (E/M) Services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

For the purposes of workers' compensation, a provider may bill a **new patient** evaluation and management service for **each new date of injury**. Additionally, a new patient visit may also be billed every three years in accordance with Health Care Financing Administration or HCFA regulations.

Levels of E/M Services

E/M codes are grouped into three categories: office visits, hospital visits, and consultations. For complete instructions on identifying and billing E/M services, refer to the Evaluation and Management Services Guidelines of the CPT[®] Manual.

E/M service descriptors have 7 components. These components are: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time.

An assessment of range of motion shall be included in the E/M service.

Range of motion shall not be paid as a separate procedure unless the procedure is medically necessary and appropriate for the patient's diagnosis and condition.

The **level of an office visit (E/M)** is not guaranteed and may change from session to session. The level of service billed must be consistent with the type of presenting complaint and supported by documentation in the record (example: a minor contusion of a finger would not appropriately be billed with a complex level of service, such as level 4 or 5).

An ice pack/hot pack is not payable as a separate service when performed solely with an evaluation and management service.

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

Office Visit With Ongoing Physical Treatment

An E/M service is **only payable in conjunction with physical treatment when:**

- Documentation supports a change in the signs and symptoms
- A separate identifiable service, other than evaluating progress in PT, is

Chapter 6 Evaluation and Management

performed (E/M billed with modifier -25)

After-Hour Services

Add on procedure codes 99050-99054 are only payable for office services when the practitioner is providing office services after normal office hours. These codes should not be reimbursed when the services occur during the provider's normal business hours (example: hospital ER or a 24-hour clinic).

Office Visits and Administration of Injectable Medication

An injection administration code for the therapeutic Injectable medication is not payable as a separate procedure when billed with an E/M service. The medication administered in the therapeutic injection shall be billed with procedure code 99070 or the appropriate J-code; and identified with the NDC code. The drug is reimbursed at the average wholesale price of the drug (AWP). If an E/M service is not billed, then the administration codes (90782-90799) may be billed in addition to the drug.

Office Visits and Administration of Immunizations

An office visit may be billed and paid separately when an immunization procedure code is billed. Immunizations are billed with procedure codes 90476-90748. An example of an immunization is tetanus toxoid vaccine. The immunization vaccines are reimbursed at the average wholesale price of the drug.

When procedure codes 90476-90748 are billed, the administration procedure is billed with 90471 or 90472 *in addition to the vaccine*.

Supplies and Material (CPT® 99070)

Supplies and materials provided by the physician or health care organization over and above those usually included with the office visit are payable by the carrier. The provider uses procedure code 99070 or the appropriate HCPCS code to describe the service. Supplies are reimbursed at AWP + not more than a 50% mark-up.

The following are *examples* of supplies usually included with the office visit:

Sterile or non-sterile dressings and tape	Antiseptic ointments, solutions & alcohol wipes	Gloves & cotton-tipped applicators
Butterfly dressings	Minor educational supplies	Syringes, medicine cups & needles
Cold or hot compress		

Follow-up Days

When a service listed in the schedule is assigned a number of follow-up days, no

Chapter 6 Evaluation and Management

payment will be made for office visits or hospital visits for routine, normal follow-up post-operative surgical care. Physicians may; however, charge for supplies (i.e.; dressings braces) furnished in the office. If the length of follow-up care goes beyond the number of follow-up days indicated, the physician will be allowed to charge for office/hospital visits.

BWUC HCSD	STATE OF MICHIGAN WORKERS' COMPENSATION FEE SCHEDULE 2003	E & M
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[cpt fee tables\e-m 02 rvu.doc](#)

Procedure Codes and descriptors are from the 2003 edition of "Physicians' Current Procedural Terminology (CPT®)"

Fees are determined by the bureau using 2002 Relative Value Unit data and a conversion factor of \$47.01

Chapter 7

Anesthesia

This section stipulates only those policies and procedures that are unique to anesthesia services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

General Information and Overview

Payment for an anesthesia service includes all usual pre-operative and post-operative visits, the anesthesia care during the procedure, and the administration of fluids and/or blood incidental to the anesthesia or surgery and usual monitoring procedures. Specialized forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included in the anesthesia base. **The anesthesia procedure code billed on the CMS 1500 reports the base units for the procedure.** Base units are determined by the ASA Guide for Anesthesiology.

To report regional or general anesthesia provided by the surgeon performing the surgical procedure see modifier -47, Anesthesia by Surgeon, discussed in Chapter 7 of this manual or in the CPT[®] manual. When anesthesia is provided by the surgeon only the base units shall be paid.

Time Reporting

Anesthesia time units are equivalent to 15-minute intervals for the actual administration of the anesthesia and 30-minute intervals for supervision of a certified registered nurse anesthetist (CRNA). Not less than the equivalent of one (15) minute unit for administration or one (30) minute unit for supervision shall be paid.

Time is reported by placing the total number of minutes for the anesthesia service in the days or units column on the CMS 1500 claim form (element 24g on the CMS 1500 12-90).

Anesthesia time begins when the anesthesiologist (or CRNA) begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance.

Determining Anesthesia Payment

Anesthesia services are reimbursed based upon total base units + total time units. Anesthesia services may be performed and billed by an anesthesiologist, a certified registered nurse anesthetist (CRNA), or both. The base units for a procedure are paid only once for the anesthesia service. Whenever multiple surgical procedures are performed, the anesthesia procedure with the greatest number of base units shall be billed to describe the anesthesia base services.

Anesthesia services must be submitted on the CMS 1500 using the anesthesia procedure code and a modifier to identify the service provider. A copy of the anesthesia record must be included. The carrier will reimburse as follows:

-AA is used when the anesthesiologist administers the anesthesia. The provider is paid \$42.00 for each base unit billed, plus \$2.80 for each minute of anesthesia administered and billed.

-SA is used when the anesthesiologist is supervising a CRNA. The provider is paid \$42.00 for each base unit billed, plus \$1.40 for each minute of supervision.

-QX is used to describe CRNA services under the supervision of the anesthesiologist. The CRNA is paid \$2.80 for each minute of anesthesia administered and billed.

-QZ is used to describe CRNA services performed without supervision of an anesthesiologist. The CRNA in this instance would be paid the same as the anesthesiologist billing with modifier -AA (base +\$2.80 per minutes).

Note: The CRNA is generally supervised in most hospitals by an anesthesiologist. **Modifier -QZ cannot be billed on the same date as Modifier -AA or Modifier -SA for an anesthesia service.**

If the anesthesiologist employs the CRNA, the anesthesia service is billed on 2 lines of the HCFA 1500. The anesthesia procedure code is billed with modifier SA designating the anesthesiologist service and again on a second line with modifier QX to represent the CRNA service.

Physical Risk Modifiers and Emergency Anesthesia

When a provider bills physical status modifiers, documentation shall be included with the bill to support the additional risk factors. The physical status modifiers are assigned unit values. When appropriate, the unit value would be added to the base units and be paid at \$42.00 per unit. The values assigned are:

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

Procedure code 99140 would be billed as an add-on procedure when an emergency condition complicates anesthesia. Documentation supporting the emergency must be included with the bill.

Chapter 7 Anesthesia

- Refer to the Health Care Services Rules, R 418.10108 (n) for a definition of emergency condition.
- On-call coverage does not meet criteria for billing 99140.

Anesthesia Fee Table, Updated 2003
Each base Unit =\$42.00

[cpt fee tables\base units-anesth.doc](#)

Chapter 8

Surgery

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

General

The schedule of maximum allowable payment (MAP) amounts for surgery lists the CPT® code, a brief description of the procedure, the MAP amount and the follow-up days (FUD). The procedures allowing a technical surgical assist (“T”) are also noted. A claim for a surgical procedure (procedure codes 10040-69990) is considered incomplete unless accompanied by an operative report. The **office notes** documenting a surgical procedure performed are also considered the operative report for those surgical procedures performed in the office setting. **Note:** 2004 CPT® has removed the designations for starred (*) surgical procedures.

Follow-up Care

During the follow-up period no payment will be made for hospital or office visits for typical postoperative follow-up care. Follow-up care for therapeutic surgical procedures includes only that care which is usually a part of the surgical service. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be separately reported.

Global Procedure (Package)

The payment for surgical procedures is based upon a global package concept. Global payment requires that the service(s) performed be identified and billed using the fewest possible CPT® codes (“unbundling” is not allowed).

The global surgical procedure includes:

- , The immediate preoperative care (a consultation or an evaluation in an emergency situation to evaluate the need for surgery is not considered part of the global procedure)
- , Local anesthesia, such as infiltration, digital, or topical anesthesia
- , The surgical procedure and application of the initial dressing, cast, or splint, including skin traction, unless excluded by the CPT® book
- , Normal, uncomplicated follow-up care (follow-up days noted in the manual).

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Note: When office visits are required to treat complications or other conditions or injuries in the follow-up period for the surgical procedure, documentation must be submitted with the charges to support medical necessity for the office visit. The E/M code billed is modified with -25.

Suture removal by the same practitioner or health care organization

The day after the service is rendered is considered Day 1 of the follow-up period.

Carrier or Employer requested visits during the global period.

When a **carrier or an employer requests** a visit during the global period for the purpose of changing or modifying a work restriction or to evaluate for a different job, the carrier will prior authorize the visit and instruct the provider to bill with 99455-32 and the carrier will pay the additional visit at \$70.00, in accord with R 418.10401 & R 418.101501. If the employer requests the visit, the employer should obtain the prior authorization number from the carrier.

Anesthesia by Surgeon

Regional anesthesia provided by the surgeon is reported by adding the modifier -47 to the basic service. The anesthesia code 01995 would be placed on a separate line of the HCFA 1500 claim form to describe the regional anesthesia and the surgeon is paid only the **base units** for the procedure.

Note: Payment is not made when infiltration, digital, or topical anesthesia is provided (local anesthesia is included in the global package).

Surgical Supplies

Supplies and material provided by the physician (eg, sterile trays/drugs), over and above those usually included with the office visit or other services rendered, may be listed separately. List drugs, trays, supplies, and materials provided. Identify as 99070.

Multiple Procedures (More than one procedure performed at a single operative session)

When the same practitioner performs multiple procedures at a single operative session, the major procedure is billed with the applicable CPT[®] code and is paid at 100% of the MAP amount. The additional or lesser procedure(s) must be billed using modifier -51. Payment for the additional procedures will be made at 50% of the listed MAP amount.

Exceptions

When the CPT[®] designates "**add-on procedure**" or "**each additional**

procedure" no modifier is appended and reimbursement is **100% of the MAP**, or the provider's usual and customary charge, whichever is less.

When **multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body is reimbursed at 100%** of the MAP amount, and the remaining procedures for each part are identified with modifier -51 and paid at 50% of the MAP amount.

Separate Procedures

A procedure designated as **"separate procedure"** in the descriptor is commonly performed as a component of a larger procedure and, as such, must not be paid as a separate service. However, when a **"separate procedure" is performed independently** of, and not immediately related to other services, it **may be billed and paid**.

Bilateral Procedures

When a CPT[®] code for a bilateral procedure is not available, report the CPT[®] code for the primary procedure on **one line** of the claim form and append with **modifier -50**. Reimbursement shall be **150% of the MAP** amount or the provider's usual and customary charge, whichever is less.

Surgical Assistant

A technical surgical assistant fee may be billed for surgical procedures designated with a "T" in the surgical section of this schedule. The **operative report must document the services of a technical assist**. An assistant surgeon's service may be billed by: a doctor of dental surgery, a doctor of podiatry, a doctor of osteopathy, a doctor of medicine, a physician's assistant or a nurse with a specialty certification (nurse practitioner or nurse midwife).

Physician Surgical Assistant: Append the procedure with modifier -80 and bill the usual and customary charge for the primary procedure. **Reimbursement will be 20% of the MAP or the provider's charge, whichever is less.**

Certified Physician's Assistant or Nurse Practitioner or Midwife as Surgical Assistant: Append the procedure with modifier -81. **Reimbursement will be 13% of the MAP, or the practitioner's usual and customary charge, whichever is less.**

Note: When an office is billing for both the primary surgeon and the technical surgical assistant, two (2) lines are used on the CMS 1500.

Co-Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a **single** reportable procedure, **each** surgeon should report his/her distinct operative work by adding Modifier -62 to the single definitive procedure. **Each** surgeon should report

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the co-surgery once using the same procedure. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate codes(s) may be reported without modifier -62.

Note: If a co-surgeon acts as an assistant for the remaining procedures, then modifier -80 may be appended as appropriate.

Multiplying the MAP amount for the surgical procedure, times 125%, and then dividing the result by 2 determines payment. **Each co-surgeon** receives half of the resulting amount or **62.5% of the MAP amount**.

Surgical Team

Under some circumstances highly complex procedures are carried out under the “surgical team” concept. Each participating physician would report the basic procedure with the addition of modifier -66.

Starred Surgical (*) Procedures

The 2004 CPT® has deleted all of the starred surgery designations for the minor surgical services. The global surgical package concept will now apply to all surgical procedure codes. Additionally, procedure code 99025 has been deleted from CPT®, therefore the appropriate initial evaluation and management level of service shall be billed to determine the treatment plan or need for surgery.

Wound Repair and Suture Removal

Payment for wound repair includes the evaluation, routine debridement, materials normally required to perform the procedure and suture removal. In the rare event that another physician, not associated with the initial physician, performs suture removal, that physician may be paid for the office visit at the appropriate level of service and list 99070 to list the suture removal kit.

Note: The following policies for reporting wound repairs listed below were adapted from the CPT® manual.

Wound repairs are classified as Simple, Intermediate, or Complex.

1. **Simple Repair:** When a wound involves only the skin and/or superficial tissues and requires simple suturing or use of adhesive. (When closure is done with adhesive strips, the surgical procedure is not charged and *only* the appropriate office visit is paid)
2. **Intermediate Repair:** When a wound involves deeper layers and requires layer closure.

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3. **Complex Repair:** When a wound is more complicated and requires more than layered closure.

Rev 2004 The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.

When multiple wounds of the same classification (see above) are repaired, add together the lengths of those wounds and report them as a single repair. When multiple wounds of more than one classification are repaired, list the more complicated as the primary procedure, and report the less complicated as the secondary procedure by listing it separately and adding modifier -51.

Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure. (For extensive debridement of soft tissue and/or bone, see CPT® codes 11040-11044).

Involvement of nerves, blood vessels, and tendons: Report under appropriate system (nervous, cardiovascular, musculoskeletal) for repair of these structures. The repair of these associated wounds is included in the primary procedure, unless it qualifies as a complex wound, in which case modifier -51 applies.

Burns, Local Treatment

Procedure code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of the burned surface(s) is required.

Procedure codes 16010-16030 must be used only when billing for treatment of second and third degree burns.

Note: If no burn treatment is done, then the appropriate E/M code should be used to describe the service.

Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately using CPT® code 11000-11044.

In order to accurately identify the proper CPT® code (codes 16010-16030) and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified in the proper section on the billing form. Percentage of body surface burned is defined as follows:

“**Small**” means less than 9 percent of the body area

“**Medium**” means 9-18 percent of the body area (e.g., whole face or whole extremity)

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“Large” means greater than 18 percent of the body area (e.g., more than one extremity)

Musculoskeletal System

Application of Casts and Strapping

Cast and strapping services (CPT[®] codes 2900-29799) may be billed and paid when the cast or strapping is a replacement procedure used during or after the follow-up care, or when the cast or strapping is an initial treatment service performed without a restorative procedure to stabilize or protect a fracture, injury or dislocation and/or to afford comfort to a patient. CPT Assistant Volume 6, Issue 2, February 1996 discusses when the casting codes are appropriately used.

The payment for a cast/strapping code includes the application and the removal of the cast, splint, or strapping. Casting supplies may be billed in addition to the procedure using 99070 or the appropriate HCPCS code, (eg, A4590).

Fracture Care

Fracture care provided during an initial visit must be billed under the appropriate CPT[®] fracture code regardless of whether the fracture is open or closed. Payment for fracture care includes the procedure and the application and removal of the first cast or traction device. Replacement casts provided during follow-up visits must be billed using the appropriate CPT[®] replacement casting and strapping codes (procedure codes 29000-29590). When follow-up days are indicated for the surgical procedure, payment may be made for replacement casts, but not for routine follow-up visits during the follow-up period. If no follow-up days are indicated, office visits may be billed and paid as appropriate.

Diagnostic or Therapeutic Nerve Blocks

A nerve block may be performed either for diagnostic or therapeutic purposes. The provider will select the appropriate procedure code from the CPT[®] book and bill as a surgical procedure.

Microsurgical Procedures

The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. **Code 69990 for microsurgery is listed separately in addition to the code for the primary procedure and is reported without modifier - 51.** Do not report code 69990 in addition to procedures where the use of the operating microscope is an inclusive component or when the magnifying loupes have been used for visual correction. Refer to the CPT[®] manual for complete listing of codes where the operating microscope is considered an inclusive component of the primary procedure.

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Chapter 9

Radiology

This section stipulates only those policies and procedures that are unique to radiology services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

General Information

Radiology services include diagnostic radiology (diagnostic imaging, diagnostic ultrasound, and nuclear medicine). Radiology services are comprised of a **professional component and a technical component**. The professional component is the physician's interpretation of the procedure, and the technical component is the equipment, supplies, and technician's services used to perform the procedure. These are discussed in greater detail later in this chapter.

Contrast Media

Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services, (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).

When a radiology CPT[®] procedure code includes the use of contrast materials in the description, no additional payment is made for the contrast materials as they are included in the procedure.

Low osmolar contrast material and paramagnetic contrast materials shall only be billed when instructions indicate supplies shall be listed separately. When appropriately billed the contrast material is reimbursed at the wholesale price and a copy of the invoice documenting the wholesale price should be attached to the charges. A supply is billed with the HCPCS code listed in the following table:

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)
A4646	Supply of low osmolar contrast material (300-399 mgs. of iodine)

X-Ray Consultation (CPT[®] 76140)

CPT[®] code 76140, x-ray consultation, will only be paid when there is a documented need for the service and when performed by a radiologist or physician certified to perform radiological services. When procedure code 76140 is billed the written report must accompany the charges.

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Note: Billing code 76140 is not appropriate in the following circumstances because review of the x-rays is included in the E/M code:

The physician, during the course of an office visit or consultation, reviews an x-ray that was were taken elsewhere.

The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

Billing

Radiologists, billing only the professional component, are not required to enter a diagnosis code in Element 21 of the CMS 1500.

When a CPT® code descriptor indicates a minimum number of views, the number listed indicates the *minimum* number of views required for that service, not the maximum. No payment will be made for views in excess of the minimum number.

Billing a Total Procedure (Professional and Technical Component)

When a physician performs both the professional and technical components, bill the appropriate CPT® radiology code without a modifier.

Billing the Professional Component (Modifier -26)

To bill for the professional component of a procedure, such as the reading of a radiology service provided by a hospital or diagnostic center, use the appropriate CPT® code and the modifier -26.

Professional services will *not* be reimbursed when:

The physician, during the course of an office visit or consultation reviews an x-ray taken elsewhere.

The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

Note: Should the provider fail to add modifier -26 to a radiology procedure provided in a hospital or other facility, payment will only be made for the professional component.

Billing the Technical Component (Modifier -TC)

When the technical component is provided by a health care provider other than the physician providing the professional component, the health care provider bills

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for the technical component by adding modifier -TC to the applicable radiology code.

Billing for Radiological Supervision and Interpretation

When a radiologist and a clinician work together as a team (e.g., when the clinician injects contrast media and the radiologist supervises and interprets the procedure) each must bill separately for services rendered.

To bill for the **service rendered by the clinician** in this case, use the applicable surgical injection procedure code. Payment for the injection includes all the usual physician services for injections (e.g., pre-and post-injection services, local anesthesia, placement of needle or catheter, and the injection itself).

To bill for the **service rendered by the radiologist**, use the applicable radiology procedure code with a descriptor that specifies "supervision and interpretation only."

Radiology Modifiers

-26 Professional Component: Radiology procedures are a combination of a physician and technical component. When only the physician professional component is reported use the modifier (-26). A written report is required whenever modifier (-26) describes the radiology service.

-TC Technical Component: Radiology procedures are a combination of a physician and technical component. When billing for only the technical component of a procedure, use the modifier (-TC). A hospital is not required to place modifiers on the UB-92; however, a carrier would process the service and pay for the technical portion (-TC) only in instances that R 418.10922 applies.

When a radiologist bills for the professional portion of a radiology procedure performed in an outpatient hospital and the procedure is being paid in accord with R 418.10916, the radiology service shall be reimbursed by the maximum allowable payment listed in the rules for the professional portion. The carrier shall not reduce the radiologist's payment by 40% as the MAP listed for the professional service is the correct payment.

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Chapter 10

Laboratory and Pathology

This section stipulates only those policies and procedures that are unique to pathology and laboratory services and are billed with CPT® codes 80048-89399. Additional policy and procedures that apply to all providers can be found in Chapters 1-5 of this manual. Most of the laboratory procedure codes do not have assigned relative value units. Some of the laboratory codes have fees promulgated by the rules and those fees are listed in Table 1501-B of the rules. All other laboratory codes without fees or relative value units assigned, are “by report” and are reimbursed at the provider’s usual and customary charge or reasonable, whichever is less.

Most of the pathology procedure codes have relative value units and the maximum allowable payment is determined by multiplying the RVU times the conversion factor.

Procedure codes in the 8000 series of codes published by CPT® may be billed by a clinical laboratory, or in some instances, by a physician’s office. Some laboratory and pathology services may require interpretation by a physician. In this case, there may be a separate bill for the technical and professional components of the procedure. The technical component is the use of the laboratory equipment and the technician’s services, and the professional component is the physician’s interpretation and report. When billing for the professional or the technical component, use the appropriate modifier. When billing for the total procedure, no modifier is required.

Laboratory and pathology procedures may be billed by a hospital as either an inpatient or outpatient service. When billed by a hospital on the UB-92, the services are identified with the appropriate CPT® procedures and the hospital is reimbursed by the ratio methodology.

Modifiers

-26 Professional Component: Pathology and lab procedures are a combination of a physician and technical component. When only the physician is reported, use the modifier (-26).

-TC Technical Component: When billing for only the technical component of a procedure, use the modifier (-TC)

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Chapter 11

Medicine

This section stipulates only those policies and procedures that are unique to the medical services covered in this section. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual. An evaluation and management service is referred to as an E/M service and is covered in Chapter 6 of this manual.

Manipulative Services

Chiropractic and osteopathic manipulative services, which are medicine services will be discussed in Chapter 12 with the physical medicine services.

Audiological Function Tests

The audiometric tests (92551-92596) require the use of calibrated electronic equipment. Other hearing tests (e.g., whisper voice or tuning fork) are considered part of the general otorhinolaryngologic services and are not paid separately. All descriptors refer to testing of both ears.

Psychological Services

Payment for a psychiatric diagnostic interview includes history and mental status determination, development of a treatment plan when necessary, and the preparation of a written report that must be submitted with the required billing form.

Psychotherapy (CPT[®] codes 90804-90857) must be billed under the CPT[®] code most closely approximating the length of the session. The codes for individual therapy services designate whether the service includes medical evaluation. Only a psychiatrist (M.D. or D.O.) may bill for those codes that include medical evaluation (procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, or 908290).

A **service level adjustment factor (SLAF)** is used to determine payment for psychotherapy when a provider other than a fully licensed psychologist provides the service(s). In those instances, the procedure codes must be identified with the **appropriate modifier identifying the provider**. The MAP amount or the provider's usual and customary fee is then reduced by the percentage for that specialty as noted in the following table:

Provider	Modifier	SLAF
Limited License Psychologist	-AL	0.85
Certified Social Worker	-AJ	0.85
Licensed Professional Counselor	-LC	0.85

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Provider	Modifier	SLAF
Licensed Marriage and Family Therapist	-MF	0.85
Limited Licensed Counselor	-CS	0.64
Limited Licensed Marriage and Family Therapist	-ML	0.64

Note: A licensed psychologist or any of the above providers may not bill psychiatrists' codes that include medical evaluation of the patient.

Examples:

- When a fully licensed psychologist bills procedure code 90806, no modifier is required and the carrier payment is 100% of the MAP amount.
- If a limited license psychologist bills procedure code 90806, modifier –AL must be added and the carrier pays 85% of the MAP amount.
- If a limited licensed marriage and family therapist bills procedure code 90806, modifier –ML must be added and the carrier pays 64% of the MAP amount.

Biofeedback

Biofeedback is billed with procedure codes 90901-90911. Providers include physicians, physical therapists, and psychologists.

Neurology and Neuromuscular Services

Neurology services are typically consultation services and any of the five levels of consultation may be appropriately billed in addition to the diagnostic studies.

Diagnostic studies (Nerve Conduction Tests, Electromyograms, Electroencephalograms, etc.) may be paid in addition to the office visit or consultative service. A diagnostic study includes both a technical component (equipment, technical personnel, supplies, etc.) and a professional component (interpreting test results, written report, etc). Billing without a modifier indicates that the complete service was provided.

Electromyography (EMG)

Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG performed on the same day. When an EMG is performed on the same day as a follow-up visit (established patient), payment may be made for the visit only when documentation supports the need for the medical service in addition to the EMG.

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Nerve Conduction

A nerve conduction study is the assessment of the motor and sensory functions of a nerve in an extremity. **Nerve conduction studies may include comparison studies when documented as medically necessary.**

Physicians may be paid for both a new patient visit/consultation and nerve conduction study performed on the same visit. When a nerve conduction study is performed on the same day as a follow-up visit, payment for the visit may be made only when documentation of medical necessity substantiates the need for the visit in addition to the nerve conduction study.

Ophthalmologic Services

Only an ophthalmologist or a doctor of optometry may bill procedure codes 92002, 92004, 92012, and 92014. A doctor of optometry shall use procedure codes 92002-92287 to describe services.

A medical diagnostic eye evaluation is an integral part of the ophthalmology service. Intermediate and comprehensive ophthalmologic services include medical diagnostic eye evaluation and services such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, and determination of refractive state, tonometry or motor evaluation.

Injectable Pharmaceuticals

Payment for injection codes includes the supplies usually required to perform the procedure, but not the medication. Injections are classified as subcutaneous, intramuscular, or intravenous. Each of the procedure codes describing a therapeutic injection has an assigned RVU and MAP amount.

Note: A therapeutic injection does not include the immunization procedure codes.

When a therapeutic injection is given during an E/M service, the relative value for providing the injection is in the payment for the E/M service and must not be billed or paid separately. The cost of the injectable pharmaceutical may be billed using procedure code 99070 from CPT[®] or the appropriate J-Code (Medicare's Level II HCPCS codes). The drug is reimbursed at average wholesale price (AWP) as determined in the current edition of Red Book.

When the injection is provided without an E/M service and only the injection will be billed for that date of service, the injection and the medication should be listed separately on the HCFA 1500. Report the injection by entering the appropriate CPT[®] injection code and report the medication as described in the preceding paragraph. The

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payment for the injection is the MAP amount listed in this schedule. Payment for the medication is AWP as determined by Red Book.

Anesthetic agents such as Xylocaine and Carbocaine used for local infiltration are included in the payment for the procedure and will not be paid separately.

Modifiers

The following modifiers are used in medical services. Consult the current CPT® manual for a complete listing of modifiers.

- AK Advanced practice nurse with a specialty certification issued by the board of nursing
- AU A certified physician's assistant
- 26 Professional component
- TC Technical component
- AH Licensed psychologist
- AL Limited license psychologist
- CS Limited licensed counselor
- LC Licensed professional counselor
- MF Licensed marriage and family therapist
- ML Limited licensed marriage and family therapist

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Chapter 12

Physical Medicine and Manipulation

This section stipulates only those policies and procedures that are unique to physical medicine and manipulative services. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

Manipulative Services

The initial office visit to determine the need for manipulative services is billed with the appropriate E/M procedure code by both chiropractic and osteopathic physicians. Ongoing manipulative services include a pre-manipulative patient evaluation. An E/M service **with ongoing manipulation** is only payable when documentation supports a significant change in signs and symptoms, or a periodic re-evaluation is required, or for the evaluation of another work related problem. **The E/M service would be reported using modifier -25.** Rationale for significant other services must be documented in the record.

The following documentation must be submitted to the carrier:

, The initial evaluation including:

1. Evaluation of function in measurable terms
2. A goal statement
3. Treatment plan
4. Physical and functional improvement in measurable terms and what improvement should be noted if therapy were to continue

, A progress report each 30 days of treatment

, A discharge evaluation

Chiropractic Manipulative Treatment (CMT) is billed with procedure codes 98940-98942. Procedure code 98943, which is not in the scope of practice for Michigan-based chiropractic physicians, is not payable to Michigan providers.

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

Chapter 12 Physical Medicine and Manipulation

Physical Medicine Services (Procedure Codes 97000-97999)

Licensed chiropractors, physicians (M.D. 's and D.O. ' s) physical and occupational therapists, dentists, and podiatrists may bill and be paid for physical medicine services (97001-97799). Physical medicine services will be paid when the therapy provided is likely to restore function and is specific to the improvement in the patient's condition.

When the treating provider (M.D., D.O., chiropractor, dentist, or podiatrist) provides physical medicine services in the office, an office visit shall not be paid when the sole purpose of the visit is to evaluate the patient's progress in physical treatment. Evaluation and management (E/M) services will be paid in addition to physical medicine services (including manipulative services) **only** when the documentation supports a significant other service is performed. **When billing the E/M service with ongoing physical medicine (or manipulation services), modifier -25 is appended to the E/M code indicating a significant other service was performed other than the physical medicine service.**

Physical therapy is when physical medicine services 97001-97799 are provided by a physical therapist and occupational therapy is when procedure codes 97001-97799 are provided by an occupational therapist. An occupational or physical therapist must not use the E/M codes to describe the evaluation, but would use procedure codes 97001-97004.

Documentation and Policies

The following documentation must be submitted:

, The **initial evaluation** including:

1. **A treatment plan** with measurable goals
2. Description of **objective findings**
3. Documentation of **limitations**, if any

, Progress report every 30 days documenting progress towards measurable goals
, Discharge summary

Note: A periodic re-evaluation is appropriately performed and is payable prior to the ending of the prescribed treatment or when the patient develops a significant change in signs or symptoms. When no progress is documented towards the goals, a re-evaluation may be done to change the treatment plan or to discontinue treatment. Ongoing therapy should not be reimbursed unless a treatment plan with measurable goals has been submitted to the carrier.

Chapter 12 Physical Medicine and Manipulation

Physical and occupational therapists will use evaluation procedure codes within the physical medicine section to describe the initial evaluation. Physicians and other providers would use the E/M service to describe the evaluation performed prior to beginning physical medicine services.

Physical treatment services are payable on the same day as the evaluation. If **therapeutic procedures are performed on the same day as the evaluation**, appropriate modalities may also be billed.

Supervised modalities, those not requiring one-on-one contact by the provider **will not be paid unless accompanied by therapeutic procedures**. (Manipulation services, procedure codes 98925-98942 are considered therapeutic procedures in addition to 97110-97546).

Constant attendance modalities, those services requiring one-on-one contact with the provider, may be billed and paid without being accompanied by the therapeutic procedures. **Phonophoresis** is billed with procedure 97035-22 and is reimbursed the same as 97035 plus \$2.00 for the active ingredient.

Functional (Work) Capacity Assessment (FCA)

Procedure **code 97750** is used to report the functional capacity testing. Total payment for the initial **testing shall not exceed 24 units or 6 hours**. A copy of the report and notes must be submitted with the bill. No more than 4 additional units shall be paid for a re-evaluation if performed within 2 months of the initial FCA.

Work Hardening and Work Conditioning

Work hardening and work conditioning are **goal-oriented therapies** designed to prepare injured workers **for their return to work**. Use procedure codes 97545 and 97546 to report these services. Work hardening procedures are considered by report as no RVU is available and the carrier will reimburse at usual and customary or reasonable, whichever is less, unless a pre-determined contractual agreement is made.

Job Site Evaluation

A carrier may request a certified occupational therapist or a registered physical therapist to complete a job site evaluation. Reimbursement for the job site evaluation is not based upon relative values, but is determined on a contractual basis between the carrier and the provider. A copy of the report must be included when submitting the bill to the carrier. The codes to bill for the job site evaluation are as follows:

Code	Work Comp Code	MAP
WC500	Job site evaluation: patient specific, initial 60 minutes	BR
WC505	Each additional 30 minutes	BR
WC550	Job site treatment; patient specific, initial 60 minutes	BR

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Code	Work Comp Code	MAP
WC555	Each additional 30 minutes	BR
WC600	Mileage for job site evaluation or job site treatment per mile	State rate

The mileage is reimbursed based upon the state approved rate that is in effect for the date of service. The state approved rate is based on the Federal Standard Mileage Rate (IRS determined rate). Travel reimbursement, for current as well as past years, is listed on the workers' compensation agency's home page www.michigan.gov/wca

Extremity Splints

Extremity splints may be prefabricated, off-the-shelf, custom-made, or custom-fit. Prefabricated splints are billed with procedure A4570 or 99070 and are payable at AWP plus not more than 50%.

When a therapist constructs a splint the service is described with procedure L3999. A report must be submitted with the bill to document the description of the splint, the time taken to construct the splint, and the charge for additional materials.

When a therapist modifies a prefabricated splint, the service would be billed with A4570 and modified with -22. A report would be included to indicate the time necessary to modify the splint and any additional material used.

Supplies

All of the supplies (e.g., electrodes and solutions) necessary to perform any of the physical medicine services are included in the MAP amount for the procedure.

If a provider dispenses a supply (e.g., lumbar roll, support, or cervical pillow), it shall be billed with procedure 99070 and the carrier will pay the average wholesale price of the supply, plus not more than a 50% mark-up. Redbook lists many average wholesale prices for the expendable medical supplies.

Medical supplies are not routinely used in the course of physical and occupational therapy. However, dressings that must be removed before treatment and replaced after treatment may be billed and paid. The supplies should be billed with 99070 or the appropriate code from Medicare's Level II HCPCS codes. Supplies are reimbursed at AWP plus not more than 50%.

Billing Guidelines

When billing physical therapy or occupational therapy, **a physician's prescription** should be attached to the charges.

CPT[®] codes 97010-97028 are **supervised modalities** for the application of a modality to one or more areas and **are not billed according to units or minutes of service.**

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CPT[®] codes 97032-97039 are for the application of a modality to one or more areas, requiring one-on-one patient contact by the provider, and are billed in 15-minute increments. CPT[™] codes 97110-97770 require one-on-one patient contact by the provider and are billed in 15-minute increments.

Procedure code 97750 is used for reporting Functional Capacity Assessment (FCA) testing and testing by means of a mechanical machine. Use of a back machine (mechanical or computerized) is also reported using 97750.

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Chapter 13

Special Reports and Services

This section lists only those policies and procedures which are unique to special reports and services. Providers may bill these codes as they apply.

Nurse Case Manager

If a carrier assigns a nurse case manager or rehabilitation nurse to a worker compensation case and the nurse accompanies the worker to the physician office visit, the provider may bill the carrier for the additional time and work involved secondary to the nurse case manager accompanying the worker.

A nurse case manager visit may be billed in conjunction with an office visit. The provider would bill the appropriate E/M procedure code and RN001. Both codes are reimbursed at 100%.

Additionally, if the case manager accompanies the worker to a routine follow-up visit during the global surgery period, the nurse case manager visit is billed with RN001. When the visit is for routine, uncomplicated care during the global surgery period, the E/M service is identified with 99024 and is not reimbursed separately as the visit is included in the global surgery package.

Carrier or Employer Requested Visits for the Purpose of Job Restrictions or Revisions

When a carrier requests that a worker be seen during the global surgery period for the purpose of reviewing a worker's job tasks, job restrictions, or to make revisions or adjustments to the worker's job, then the carrier will reimburse the provider for the visit even though the visit occurs within the global follow-up period for the surgery.

The carrier is required to prior authorize the visit and must not deny the visit. The provider will bill the visit with procedure code 99455 using modifier 32 for carrier mandated service. The carrier shall reimburse 99455-32 at the amount listed in Table 1501-A of the HealthCare Services Rules.

Carrier Requested Reports

If a carrier requests the provider to generate a report that is over and above the reports contained within the medical record, then the carrier must reimburse the provider for that report. The provider will bill the report with procedure code 99199 using modifier 32 for carrier requested service.

The carrier will reimburse the provider at \$25.00 per page if the report is 3 pages or less. If the report is more extensive then reimbursement shall be considered "by

Chapter 13 Special Reports and Services

report.” Because the rules do not prohibit the carrier and provider from entering into a contractual agreement this report could also be reimbursed contractually.

Copies of Reports and Records

Providers are required to include certain copies of the medical record (refer to R 418.10113, R 418.10212, and R 418.10901(3)) when submitting claims and may not charge the carrier for those required reports. When the carrier (or the carrier’s agent) requests additional medical records pertaining to a **specific date of injury** or duplicate copies of the medical record, the provider may bill for those records. The carrier will reimburse the provider for the additional records or duplicate copies as follows:

- 25 cents per page, plus
- The actual cost of mailing the records, plus
- A handling fee outlined in the following table:

0-30 minutes	\$3.50
31-60 minutes	\$7.00
Each additional 30 minute increment	\$3.50

Medical records pertaining to a specific date of injury may be requested by:

- A carrier or their agent (attorney or review company)
- An injured worker or their agent (attorney)

Note: The provider may bill their usual and customary charge for records that do not pertain to a specific date of injury (other than the case record).

Services Occurring "After Hours"

When an office service occurs after a provider’s normal business hours, procedure codes 99050-99058 may be billed. Payment shall not be made for these codes when the service occurs during the provider’s normal hours of business (e.g., emergency room or clinics that are open 16-24 hours of the day).

Miscellaneous Procedures. (See Rule 418.101502)

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		Rehabilitation or case manager visit (R418.10121)	\$25.00

Chapter 14

Ancillary Services

This section contains information specific to ancillary services. The services cited in this chapter (with the exception of the L-Code procedures) are considered "by report" and do not have assigned fees. Refer to Medicare's National Level II HCPCS for a complete listing of all ancillary procedures. Fees for the L-Code procedures will be published in the Health Care Services Rules in R 418.101504. In addition, this section also includes specific workers' compensation codes for billing home health services.

The following services are considered ancillary services. The ancillary service(s) provided to treat a covered work injury or illness is covered under the Workers' Disability Compensation Act and the Health Care Services Rules. A complete listing of all of the procedure codes used for the following services may be found in Medicare's National Level II HCPCS:

- **Ambulance Services** (Codes A0021-A0999)
- **Expendable Medical and Surgical Supplies** (A4000-A8999)
- **Dental Procedures** (D0120-D9999)

Note: Omitting the "D" preceding the procedure may also be seen and is acceptable when billing dental procedures.

- **Durable Medical Equipment** (E0100-E9999)
- **Orthotic and Prosthetic Procedures** (L0000-L9999)
- **Vision Services** (V0000-V2999)
- **Hearing Services** (V5000-V5999)
- **Home Health Services** (Primarily found in S-Section, temporary national codes)

The durable medical and expendable medical supplies are reimbursed at average wholesale price (AWP), plus not more than 50%. When billing durable medical supplies, a copy of the prescription is attached to the bill.

Chapter 14 Ancillary Services

There are no set fees for the ancillary services and with exception of dental services; the following services are practitioner services, billed on the HCFA 1500 claim form. Dental services are billed using the Standard American Dental claim form.

All services noted below are reimbursed “by report”, BR. This means the service is reimbursed at either the practitioner’s usual and customary charge or reasonable, whichever is less. Definitions for usual and customary are found in R 418.10109.

- Ambulance services
- Dental services
- Home health services
- Hearing services
- Vision services

“Reasonable amount” is defined as a payment based upon the amount generally paid in the state for a particular procedure code. Generally, data from all other payers across the board is considered when determining reasonable payment.

“Usual and Customary charge” means a particular provider’s average charge for a procedure to all payment sources, calculated based on data beginning January 1, 1995.

Home Health Services

The home health services for worker’ compensation in Michigan are billed on the UB-92 claim form submitted to the carrier using procedure codes from either the S or G series of procedure codes from HCPCS, Medicare’ s Level II as adopted by reference in R 418.10107

If a home health agency bills for therapy services by an occupational therapist, a physical therapist, or a speech and language pathologist, the agency will use the appropriate HCPCS coding to describe the therapy services.

A home health agency may bill supplies using the appropriate supply code from the HCPCS Medicare Level II book, adopted by reference in R 418.10107. Progress notes will be submitted with the charges to document the services and supplies on the bill.

There are no set fees for the home health services. Any of the practitioner services rendered in the home are by report and are reimbursed at either the provider’s usual and customary charge as defined in the rules or reasonable, whichever is less. Therapy services may be reimbursed at a per diem rate when the code is described as a per diem service or by the total time of the service if the procedure billed indicates it is time-based. Per-diem would be a daily rate or visit. Supplies dispensed as part of the home care service are reimbursed as in the next paragraph.

Chapter 14 Ancillary Services

Supplies

Expendable medical supplies and durable medical equipment are paid at the average wholesale price, plus a markup of not more than 50% above average wholesale price. The Redbook, as adopted in the Health Care Services Rules, R 418.10107, lists many of the wholesale prices for the expendable medical supplies.

Orthotic and Prosthetic Services

The treating practitioner prescribes orthotic or prosthetic services. When these services are billed, a copy of the prescription is included with the charges. Orthotic equipment or orthosis means an orthopedic apparatus or device that is designed to support, align, prevent, or correct deformities of, or improve the function of, a moveable body part. An orthotist is a practitioner skilled in the design, fabrication, and fitting of an orthosis or orthotic equipment. Orthotic equipment may be any of the following:

- Custom-fit which means the device is fitted to a specific patient.
- Custom-fabricated which mean the device is made for a specific patient from individualized measurements, pattern, or both.
- Non-custom supply means that the device is prefabricated, off-the-shelf, requires little or no fitting, and minimal instruction. A non-custom supply is intended for short-term use and does not include prosthetic procedures.

Prosthesis means an artificial limb or substitute for a missing body part. A prosthesis is constructed by a prosthetist, a practitioner who is skilled in the design, fabrication, and fitting of artificial limbs or prosthesis.

An orthotic or prosthetic procedure code that does not have an assigned fee is considered “by report” and requires a written description accompanying the charges on the HCFA 1500 claim form. The report shall include:

- Date of service
- A description of the service provided
- The time involved
- The charge for materials/components

The L-Code procedures with assigned maximum allowable payments are listed in The Health Care Services Rules in R 418.101504.

Chapter 15

Hospital and Facility Services

This section stipulates policies and procedures that are unique to hospitals and other facilities. Additional policies and procedures that apply to all providers are listed in Chapters 1-5 of this manual.

General Information and Overview

Facilities that are licensed by the state of Michigan will be paid in accord with the Health Care Services Rules for services provided to injured workers. A carrier is not required to pay for facility services when a facility is not licensed. A facility may not balance-bill an injured worker for compensable services rendered to treat a work related illness or injury.

When a hospital located outside the state of Michigan bills a carrier for services rendered to a Michigan injured worker, the carrier should use the out-of-state ratio to process the charges. If the out-of-state hospital does not accept the Michigan fee schedule, the carrier must resolve the issue with the provider to prevent the Michigan injured worker from being balance-billed.

Licensed Facility Services (including hospitals)

A facility, as defined by the Health Care Services Rules, shall submit facility charges on a UB-92 claim form to the carrier. The "Michigan Uniform Billing Manual" contains instructions for facility billing and can be ordered from the Michigan Health and Hospital Association, 6215 West St. Joseph Hwy, Lansing MI, 48917, (517) 323-3443.

A hospital or a facility shall include the following information on the UB-92 claim form:

- , Revenue codes
- , ICD.9.CM code
- , CPT[®] codes identifying the surgical, radiological, laboratory, medicine, and E/M services

A hospital billing for outpatient laboratory or physical medicine services, (e.g., physical and occupational therapy and speech therapy) will identify the services performed with revenue codes. CPT[®] procedural coding is not required for PT, OT, and speech therapy performed in the hospital setting as the services are reimbursed by the ratio methodology. Refer to Part 9, Section B, of the Health Care Rules for facility billing. Reimbursement for facility services is found in Part 10, Section B, of the Workers' Compensation Health Care Services Rules.

Chapter 15 Hospital and Facility Services

A facility billing for a practitioner service shall submit the charges on the CMS 1500 claim form.

Examples of Facility Billing for Practitioner Services:

- , A hospital billing for a CRNA or anesthesiologist, or both
- , A hospital billing for a radiologist
- , Professional component of a laboratory or medicine service
- , A hospital or hospital system-owned occupational or industrial clinic
- , A hospital or hospital system-owned office practice

Facility other than a Hospital

A licensed facility other than a hospital must also use the UB-92 claim form to submit charges and must follow the billing procedures outlined in the UB-92 Billing Manual. A licensed facility other than a hospital will be reimbursed not more than the provider's usual and customary charge or reasonable amount, whichever is less.

When a licensed facility other than a hospital bills radiology or laboratory services, only the technical services shall be billed on the UB-92 claim form. Any professional charges, including anesthesiology services, shall be billed on the CMS 1500 claim form.

Note: To verify facility licensure, the carrier may contact the Bureau of Health Systems at (517) 241-2626. A booklet listing all of the licensed facilities and the addresses can be purchased from the Bureau of Health Systems, PO Box 30664, Lansing MI, 48909.

Reimbursement for Hospital Facility Services

Hospital Ratio Payment Methodology

The following hospital services are paid by the ratio methodology:

- Inpatient or observation care
- Emergency department care
- Physical medicine services (occupational, physical, and speech therapy)
- Outpatient surgery services
- Laboratory services and outpatient services not listed in Table 10922 of the Health Care Services Rules, R 418.1010922.

Note: The following "technical" services performed in the hospital would not have professional components and must also be paid by the ratio methodology:

Chapter 15 Hospital and Facility Services

1. Casting and strapping procedures performed by hospital technicians
2. EKG, tracing only procedures

Note: Procedure codes describing **professional service** only **shall not be included on the UB-92**. Examples: 53670, 93000, 93015, 93040, and 93720.

Calculating Hospital Payments by Ratio Methodology

The carrier will use the following formulas to calculate hospital reimbursement for ratio methodology payments:

Paying a properly submitted bill within 30 days:

(Appropriate charges x hospital ratio for the date of service x 107%)

Paying a properly submitted bill after 30 days:

(Appropriate charges x hospital ratio for the date of service x 110%)

Billing for Facility Component of Minor Services Performed in the Outpatient Hospital Setting

When procedures located in Table 10922 are performed in the outpatient hospital setting after the initial 10 days of care for an injury, the hospital shall only be paid either the technical component of the procedure listed in the rules or 60% of the MAP for the medical and surgical procedure codes if no technical component is listed. When radiology procedures are performed in the outpatient facility after the initial 10 days of care, the hospital will be paid by the relative value for the technical component (-TC) of the procedure.

The minor procedures listed in Table 10922 are those procedures that could safely be performed in settings other than an outpatient hospital and concerns the technical portion of the procedure only.

The following are exceptions to this rule and are paid by ratio methodology:

1. Services received in the **first 10 days of commencing care** for a work injury
2. **Inpatient or observation stays or services appropriately performed in an emergency room** (ex: Urgent or emergency services performed after the first 10 days of care that are required after the treating practitioner's routine office hours)
3. **Outpatient surgery**
4. When service is combined with another procedure not considered to be minor (**ex: a cat scan, a minor procedure in Table 10922, performed with a myelogram** or other outpatient surgery)

Chapter 15 Hospital and Facility Services

Note: The following table was excerpted from the Health Care Services Rules, R 418.10922:

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	

Table 10922 listed above for the facility component of the service corresponds to Table 10916 listed below. The corresponding Table 10916 was also excerpted from the Health Care Services Rules and concerns the practitioner portion for the services on the table.

Billing for Practitioner Component for Minor Services Performed in the Outpatient Hospital

When a practitioner performs a procedure from Table 10916 in the outpatient hospital setting, the practitioner must identify the service with modifier -26 to signify the professional component and will be paid 40% of the MAP allowance.

Exceptions to the practitioner services in Table 10916 are as follows:

An emergency room physician providing emergency room services is paid at 100% of the MAP

Note: Hospital occupational clinics are required to bill all services on the CMS 1500 as a practitioner service, using site of service "3". The hospital should not "split-bill" with facility charges on the UB-92 and professional charges on the CMS 1500. The hospital occupational clinic shall be paid as a practitioner and receive 100% of the MAP amounts listed in this manual.

Chapter 15 Hospital and Facility Services

TABLE 10916				
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	

Chapter 15 Hospital and Facility Services

[..\Fees using 2002 RVUs\Excel 02 Fees\Hospital ratio 10-31-2002.xls](#)

Chapter 16

Agency and Miscellaneous Information

This section contains contact information and examples of the forms used in workers' compensation. Also included in this chapter are samples of the provider claim forms.

Agency Contact Numbers

A provider may call (517) 322-1885 or (888) 396-5041(prompt #2) to obtain **carrier information**. When calling, be sure to have the following information:

- The employer's name and address
- The date of injury

Workers' compensation forms (including 104B forms) and information may be obtained by calling (888) 396-5041(prompt #3). Requests for forms can either be e-mailed to <http://www.wcinfo@michigan.gov/> or faxed to 517-322-1808. All requests should include a contact name, phone number, company, street address, city, state, zip code, the requested form name and/or number, and quantity. In addition, you may print forms directly from our website: www.michigan.gov/wca
Questions from an **injured worker** may be directed to (517) 322-1980 or (888) 396-5041(prompt #1 from the first menu then prompt #1 from the 2nd).

Fee schedule and billing questions may be directed to (517) 322-5896, (517) 322-5433 or (888) 396-5041(prompt #6).

To **request a copy of the Health Care Services Rules or Fee Schedule** call **(517) 322-5433 or (888) 396-5041(prompt #6)**. The Health Care Services Rules and Fee Schedule may be downloaded at no charge from the workers' compensation agency's website: <http://www.michigan.gov/wca>.

Providers with questions about completing the **104B form** may call (517) 322-5430 or (888) 396-5041(prompt #6). Other questions may be directed to (517) 322-5991 or (888) 396-5041(prompt #8).

Note: Hearings are generally scheduled within 6-8 weeks. Allow for this processing time to elapse before contacting the workers' compensation agency.

Carriers may direct questions regarding the completion of the forms, "Annual Medical Payment Report" or "Certification of the Carriers' Professional Review Program" to (517) 322-5430 or (888) 396-5041(prompt #6).

Claim Forms

- , The standard practitioner claim form is the most recent 1500 form (12-90).
- , The standard facility claim form is the UB-92 form.
- , The standard ADA claim form (dental claim form).
- , The universal pharmacy claim form.

Agency Forms

- , **“Sample Reconsideration”** This is not a required form and is optional for provider usage.
- , **“Provider’s Report of Claim”** (117H) This is not a required form and is not sent in to the workers’ compensation agency. Provider use of the form is optional when an employer does not report the claim.
- , **“Application for Mediation”** (104B). Forms are ordered from the workers’ compensation agency s the original orange-colored form must be submitted.
- , **“Carriers Explanation of Benefits”**
- , **“Annual Medical Payment”**
- , **“A Hospital’s Request for Adjustment to their Maximum Payment Ratio”**
- , **“Application for Certification of a Carrier’s Professional Health Care Review Program”**
- , **“Notice of Certification of a Carrier’s Professional Health Care Review Program”**

SOURCE DOCUMENTS

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

- , Physicians Current Procedural Terminology (CPT[®])
- , Medicare’s National Level II Codes, HCPCS
- , RBRVS, Fee Schedule: The Physicians’ Guide
- , International Classification of Diseases
- , Red Book
- , Michigan Uniform Billing Manual
- , Relative Value Guide: ASA Guide for Anesthesia Values

Sample Reconsideration

**WORKER'S COMPENSATION HEALTH CARE SERVICES
PROVIDER'S REQUEST FOR RECONSIDERATION**

COPY 1 CARRIER COPY 2 PROVIDER

REQUEST DATE

PROVIDER NAME			EMPLOYEE NAME		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
SOCIAL SECURITY/FEIN NUMBER*			SOCIAL SECURITY NUMBER*		
PATIENT ACCOUNT NUMBER			DATE OF BILL	DATE OF INJURY	

CARRIER NAME				TELEPHONE NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE	CLAIM NUMBER
EMPLOYER NAME				

DATE(S) OF SERVICE

CHARGE	\$	PAYMENT	\$	REQUESTED AMOUNT	\$
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REASONS FOR RECONSIDERATION (Detailed Statement)
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DOCUMENTS ATTACHED:		BWC-739		REQUESTED REPORT
		OFFICE NOTES		BILL

CONTACT PERSON AND TELEPHONE NUMBER

*PROTECTED INFORMATION TO BE USED FOR IDENTIFICATION PURPOSES

APPLICATION FOR CERTIFICATION OF A CARRIERS' PROFESSIONAL HEALTH CARE REVIEW PROGRAM

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Date of Application	Initial <input type="checkbox"/>	Renewal <input type="checkbox"/>
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Note: A new application must be submitted whenever there is a change in carrier, service company, or review company.

This form is required in accordance with Part 12, R 418.101206 of the Worker's Compensation Health Care Services Rules to receive certification of a carrier's professional review program.

I. CARRIER

Carrier	Service Company	Review Company
NAIC NO., Self-Insured No., or FEIN	Agency Assigned Number	Employer Identification
Name	Name	Name
Address (Street)	Address (Street)	Address (Street)
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Telephone No. (Include area code)	Telephone No. (Include area code)	Telephone No. (Include area code)
Contact Person	Contact Person	Contact Person

II. METHODOLOGY/REVIEW STAFF AND CREDENTIALS

Attach methodology, according to the workers' comp agency procedure, used to perform a carrier's professional review.

R 418.101204(5)(a)-(c) requires that medical appropriateness of services shall be determined through one of the following approaches:

- 1) Review by licensed, registered, or certified health care professionals.
- 2) The application by others of criteria developed by licensed, registered, or certified health care professionals.
- 3) A combination of (1) and (2) according to the type of covered injury or illness.

The methodology should include a list of all licensed, registered, or certified health care professionals reviewing case records and medical bills for the above carrier. Provide current licensure information (license #, state of issue, date of expiration and restrictions) and qualifications for medical bill review. In addition, include a list of all peer reviewers with current license information and specialty.

*When a service company submits applications for numerous self-insured employers, and the methodology is identical, it is not necessary to submit the professional review methodology more than once. The workers' compensation agency will maintain on file, the review methodology for each service company.

**Methodology for professional certification must be submitted once every three years or whenever changes occur.

III. AUTHORIZED SIGNATURE

By signing this form, I certify that the information included on this form is correct and complete to the best of my knowledge and that the professional review methodology is attached or has already been submitted by the service company and/or their designated agent. I understand that submitting false information is cause for denial of the application or will subject me to penalties as provided by law.

Authorized Signature (In Ink)	Authorized Name (Typed)	Date
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ANNUAL MEDICAL PAYMENT REPORT

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Due by February 28th Year Ending 200_

I. CARRIER INFORMATION

Carrier Name	Carrier NAIC No., Self-Insured No., or FEIN No
Carrier Address (Street)	Carrier Telephone No. (Include area code)
Carrier City, State, ZIP Code	Carrier Contact Person
Service company or Review Company submitting the Information	Contact Person and Telephone No. (Include area code)

II. ANNUAL MEDICAL PAYMENT REPORT

Include data for payment of all medical expenditures.

Do not include payments for the following:

- a. Indemnity payments
- b. Mileage reimbursement
- c. Vocational rehabilitation or medical case management expenses
- d. Independent medical examinations or legal expenses

Case Type	Number of Cases	Total Dollars Spent for Medical Care
Medical Only		\$
Wage Loss		\$

By signing this form, I certify that the information included in this annual medical payment report and accompanying attachments, if any, is true, correct and complete to the best of my knowledge.

Authorized Signature (In ink)	Authorized Name (Typed)	Date
-------------------------------	-------------------------	------

Authority: Workers' Compensation Health Care Services Rules, part 14, R 418.101401
Completion: Mandatory. Must completed and submitted to the agency by 2/28 annually for the previous year.
Penalty: Failure to provide data shall prevent certification of the Carrier's Professional Health Care Review Program pursuant to Part 12, R 418.101206

APPLICATION FOR ADJUSTMENT TO THE WORKER'S COMPENSATION MAXIMUM PAYMENT RATIO

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Application Date	
Fiscal Year	

This form is required in accordance with Part 11, R 418.101103 of the Worker's Compensation Health Care Services Rules for an adjustment to the worker's compensation maximum payment ratio. A Hospital should not submit the form unless the hospital is eligible to receive an increased adjustment in accord with R 418.101103.

I. Hospital	
Name	Employer Identification Number
Address (Street)	Telephone No. (Include area code)
City, State, ZIP Code	Contact Person

II. Cost Information	
This information is required pursuant to R 418.101102 for the calculation and revision of the maximum payment ratio. All information below should be for a hospital's most recent completed fiscal year.	
a. Enter total operating expenses for most recent year as reported on the "statement of patient revenues and operating expenses, G2 worksheet."	\$
b. Enter total patient revenues for most recent fiscal year as reported on the "statement of patient revenues and operating expenses, G2 worksheet."	\$
c. Total charges for all worker's compensation cases.	\$

By signing this form, I certify that the information included on this form and accompanying attachments, if any, is true, correct, and complete to the best of my knowledge. I understand that submitting false information is cause for denial of the underpayment adjustment or will subject me to penalties as provided by law.

Authorized Signature (In ink)	Authorized Name (Typed)	Telephone No. (Including Area Code)	Date

Copy 1 Health Care Services Division
Copy 2 Hospital

Carrier's Explanation of Benefits

State of Michigan Department of Consumer and Industry Services
Bureau of Workers' Disability Compensation
Health Care Services Division

Copy 1	Provider
Copy 2	Carrier
Copy 3	Employee

Date processed
Page

DIRECT ALL PAYMENT INQUIRIES AND REQUESTS FOR RECONSIDERATION TO THE CARRIER

Carrier Name			Service Company			NAICS/Self-Insured		
Street Address			City	State	Zip Code	Telephone Number		
Employer Name						Claim Number		
Provider Name				Employee Name				
Street Address				Street Address				
City		State	Zip Code	City		State	Zip Code	
Social Security/FEIN Number*				Social Security Number *				
Patient Account Number				Date of Injury	Date of the Provider Bill	Date bill received by Carrier		
PROVIDER: IF YOU INTEND TO SEEK RECONSIDERATION, PLEASE CONTACT THE CARRIER INDICATED ABOVE WITHIN 60 CALENDAR DAYS OF RECEIPT OF THIS NOTICE. IF ADDITIONAL INFORMATION IS REQUESTED, PLEASE FORWARD THE INFORMATION TO THE CARRIER.				EMPLOYEE: FOR INFORMATION ONLY. THIS IS NOT A BILL. IF YOU ARE BILLED FOR ANY SERVICES RELATED TO THIS WORKERS' COMPENSATION CLAIM, DO NOT PAY. DO CALL THE CARRIER LISTED ABOVE.				
Date of Service	Place of Service	Procedure Code and Modifier	Description--If Needed	Diagnosis Code	Days or Units	Charge	Payment	Note
THIS IS NOT A BILL								
Provider/Employee: R 418.10105 and R 418.101301(3) of the Worker's Compensation Health Care Services Rules require that the carrier 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 when that 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. The carrier shall request the employee to notify the carrier if the provider bills the employee.							Total Charge	Payment

This form is required as set forth in Part 10, R 418.101001 (4) and Part 13 R 418.101301 (1) and (4) of the Workers' Compensation Health Care Services Rules.

***PROTECTED INFORMATION TO BE USED FOR IDENTIFICATION PURPOSES**

WCA-739 (Rev.1-04)

Application for Mediation Form B

This form, commonly known as a 104B, is submitted on behalf of: Health Care Providers, Insurance Companies, or Self-Insured Employers to resolve disputes involving medical services.

This form must be filed on the original orange form obtained from the workers' compensation agency. You may order by fax at (517) 322-1808 or by phone (888) 396-5041, or e-mail your request to www.wcinfo@michigan.gov.

Practitioner Claim Form CMS-1500

A copy of this form may be downloaded from the Internet at: <http://cms.hhs.gov/providers/edi/cms1500.pdf> or by contacting the AMA at (800) 621-8335.

Facility Claim Form UB-92 CMS-1450

A copy of this form may be downloaded from the Internet at: <http://www.cms.hhs.gov/providers/edi/h1450.pdf>