State of Michigan
Workers' Compensation Agency
Resolution, Rehabilitation & Rules Division
Health Care Services Rules Update
Ruleset Effective January 8, 2019

Health Care Services
Rules v Manual

*Promulgate rules governing health care services under the Michigan Workers' Disability Compensation Act of 1969.

*Identified by the R418. distinction

*Is designed to be user friendly.

*Any reference in the manual to "MCL418" relates to the statute.

*Any conflicts between the language of the manual and the rules, the language of the rules controls.

Providers billing "30-30-60"

If no response within
30 Days
of initial billing

Submit a second bill with request for 3% late fee.

If no response within
30 Days
of second billing

File a WC-104B.

Reconsideration must be made within
60 Days

If response is received (payment/denial), that provider does not agree with. Failure to do a reconsideration within 60 days may preclude the provider from further action by the Workers' Compensation Agency.

Carrier's Response to Providers Request of Reconsideration

R 418.101303

(1)Within 30 days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and provide a detailed statement of the reasons.

(2) A provider shall send its application for hearing to the agency within 30 days from the date of the receipt of a carrier's denial of this provider's request for reconsideration.

(3) If, within 60 days of the provider's request for reconsideration, the provider does not receive payment for the adjusted or rejected bill, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may apply for hearing.

WC-104B

Required information

*Employee name

*Full Social Security Number

*Employee Date of Birth

*Employer Information

*Insurance Company, if one is being billed

EVERYONE SHOULD BE USING THE 09/2013 VERSION.

Available on our website:

www.Michigan.gov/wca

Filing a WC-104B

Why

*For assistance in resolving payment issues with the carrier.

*To be added as an intervening party if the case is in litigation.

*To get in front of a magistrate.

When

*No less than 60 days from the initial billing.

*When you learn a case is in litigation and there are outstanding balances.

*After request for reconsideration has been submitted without resolution.

What You Need to Know

*What services were rendered on the date of service.

*Original billed amount.

*Date & amount of any payment received.

*Date of first reconsideration.

*Who has contact been made with, their telephone number and extension.

*Outcome of the contact.

Withdrawing a WC-104B

*Sign the bottom of the hearing notice

*Fax ONLY the signed hearing notice

*Do NOT send a cover sheet, letter, copy of the WC-104B.

WC-104B Moves to the Magistrate

*Provider representative should come in for at least 1 hearing after the pretrial.

*Discuss with magistrate and other attorneys.

*You can not talk to the magistrate without other parties present.

*Bring copies of bills/medical records

*Don't depend on other counsel to defend your case.

Litigate Case v. Disputed Case

Litigated case

*WC-104A has been filed.

*Injured worker is pursuing their claim through litigation.

Disputed Case

*W-107, Notice of Dispute, has been filed by the carrier.

*If the injured worker does not file a WC-104A, then in the eyes of the state, the dispute stands.

What to do if a case is in litigation

*If there are outstanding bills, file a WC-104B.
*Send copies of outstanding bills to the injured worker and their attorney.
*Obtain a copy of the Notice of Dispute.
*Submit the bills to the injured worker's health insurance.

Copy Charge for Medical Records

*Only those records for a specific date of injury are covered under the HCS Rules.

*The rules do not pertain to medical records requested by subpoena that are part of litigation.

*For records other than those applying to the specific date of injury, the provider may bill their usual and customary charge.

*Requesting party shall pay the copying charge.

Requests for Existing Medical Records and Reports

R418.10114

*There is nothing in the HCS Rules that preclude a carrier, a carriers agent, and employee, or and employee agent from requesting additional existing medical records and reports related to a **specific date of injury**.

Requests for Existing Medical Records & Reports continued

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

*Complex reports greater that 3 pages in length or record review shall b reimbursed on a contractual basis between the carrier and the provider.

Nurse Case Managers

R418.10121

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

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

No Record of Coverage

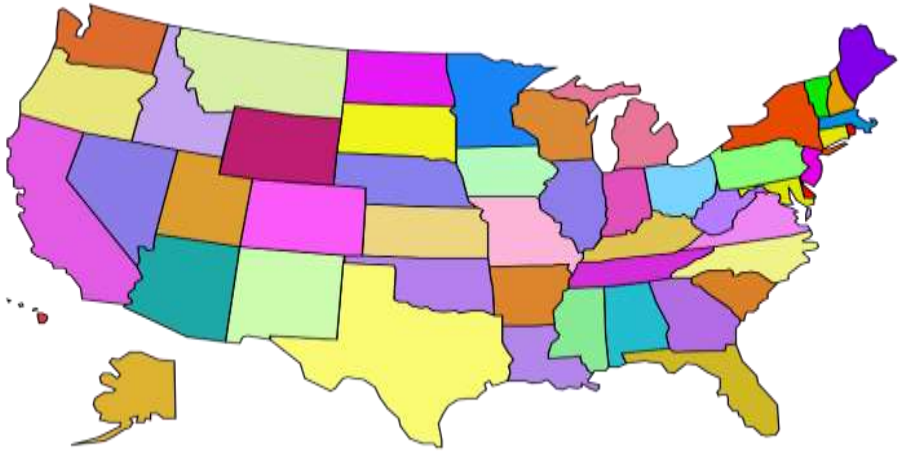
Look at the employees address.

Look at the employers address.

Is there a claim under another states jurisdiction.

Call the employer to determine if they have a workers' comp policy.

Jurisdiction is forever



Are you speaking the same language?

What does "Claim" mean to you?

Health Care Provider

A "claim" is the bill that is submitted to the carrier for services rendered to the injured employee..

Carrier

A "claim" is the file set up to investigate the alleged injury and pay the appropriate benefits, if owed.

2018 Health Care Services Rules

The updated rules, manual and fee schedule are based on 2018 source documents such as the 2018 October release CMS Physicians Fee Schedule, as well as 2018 CPT® and HCPCS® Level II procedure codes. Some highlights of the updated rule language include:

A. Updated source document listings.

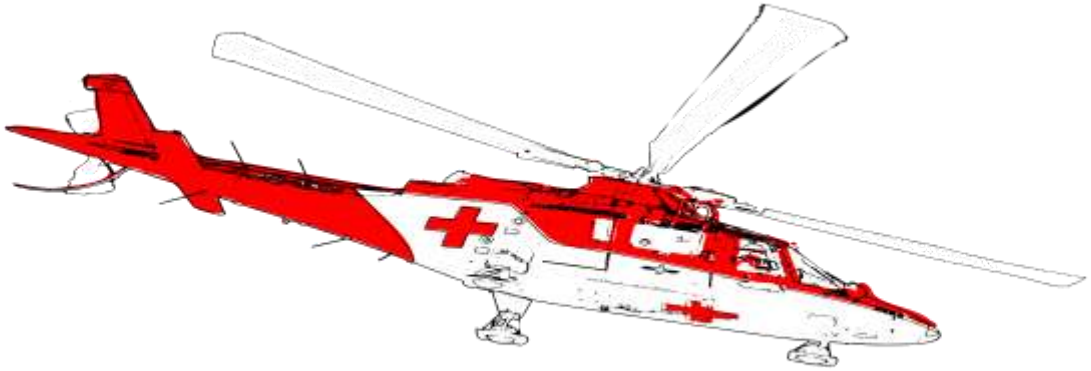
B. Updated conversion factor: up to $47.66 from $47.19.

C. New definition and rule language regarding Telemedicine Services.

Hospital cost-to-charge ratios updated every August.

Air Ambulance

Effective March 15, 2018



Air Ambulance continued

*R 418.10926 & R 418.101010

*Billed on CMS 1500. Codes used to bill include A0430, A0431, A0435, A0436 (depending if rotary or fixed wing).

*Maximum allowable reimbursement based on Medicare (CMS) rate x 1.40.

*Map utilizes the practice expense (PE) of the geographical information (GPCI) using a melded average of 60% of figures for city of Detroit and 40% of the figures published for the rest of the state. Geographic adjustment factor is applied to 50% of the base rate for A0430 & A0431.

Air Ambulance continued

*Rural or urban rate depends on air ambulance point of pick up zip code.

*Mileage reimbursed per documented loaded patient miles flown. Rounded to the nearest tenth for trips up to 100 miles, rounded to nearest whole number for trips totaling 100 covered miles or more.

*Air Ambulance provider owned by hospital and billing with same tax ID number as hospital is reimbursed based on hospital's cost-to-charge ratio.

Air Ambulance Rates

CPT Code	MI Urban Rate	MI Rural Rate
A0430	$4,186.31	$6,279.46
A0431	$4,867.21	$7,300.82
A0435	$12.11	$18.17
A0436	$32.33	$48.50

Telemedicine:

How is it billed? How is it reimbursed?

Telemedicine

*Use of an electronic media to link patients with health care professionals in different locations.

*To be considered telemedicine, the health care professional must be able to examine via real-time, interactive audio and video telecommunications system, and the patient must be able to interact with the off-site health care professional at the time the services are provided.

Billing for Telemedicine Services

R418-10901(4)

A health care professional billing for telemedicine services shall only utilize procedure codes listed in Appendix P of the CPT codebook...to describe services provided excluding CPT codes 99241-99245 and 99251-99255. The provider shall append modifier -95 to the procedure code to indicate synchronous telemedicine services rendered vis a real-time interactive audio and video telecommunications system with place of service code -02. All other applicable modifiers shall be appended in addition to modifier -95.

Modifier Code Reimbursement

R418-101004(14)

*When modifier -95 is used with a procedure code listed in Appendix P of the CPT codebook...excluding CPT codes 99241-99245 and 99251-99255, the telemedicine services shall be reimbursed according to all of the following:

Modified Code Reimbursement continued

(a) The carrier shall reimburse the procedure code at the non-facility maximum allowable payment, or the billed charge, whichever is less.

(b) Supplies and costs for the telemedicine data collection, storage, or transmission shall not be unbundled and reimbursed separately.

(c) Originating site facility fees shall not be separately reimbursed.

Reimbursement for Dispensed Medications

R418.101003a

(1) Prescription medication shall be reimbursed at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span. All of the following shall apply:

(a) The dispensing fee for a brand name drug shall be $3.30 and shall be billed with WC-700-B.

(b) The dispensing fee for a generic drug shall be $5.50 and shall be billed with WC-700-G.

Reimbursement of Dispensed Medications continued

(e) When an original manufacturer's NDC number is not available in either Red Book or Medi-Span and a pharmaceutical is billed using an unlisted or "not otherwise specified code", the payer shall select the most closely related NDC number to use for reimbursement of the pharmaceutical.

Reimbursement of Dispensed Medications continued

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

Reimbursement of Dispensed Medications continued

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

Examples of these types of medications include, but are not limited to Dendracin, Lenzagel, and Medrox.

Reimbursement for Custom Compound Topical Medication

R418.101009

(1) A custom compound topical medication...shall be reimbursed only when the compound meets all of the following standards:

(a) There is no readily available commercially manufactured equivalent product.

(b) No other FDA approved alternative drug is appropriate for the patient.

(c) The active ingredients of the compound each have an NDC number and are components of drugs approved by the FDA.

Reimbursement of Custom Compound Topical Medications continued

(d) The drug has not been withdrawn or removed from the market for safety reasons.

(e) The prescriber is able to demonstrate to the payer that the compound medication is clinically appropriate for the intended use.

(2) Topical compound drugs or medications shall be billed using the specific amount of each component drug and its original NDC number included in the compound. Reimbursement shall be based on a maximum reimbursement of the AWP minus 10% based upon the original manufacturer's NDC number...and pro-rated for each compound used. Components without NDC numbers shall not be reimbursed. A single dispensing fee for a compound prescription shall be $12.50 for a non-sterile compound. The dispensing fee for a compound prescription shall be billed with code WC700-C. The provider shall dispense a 30-day supply per prescription.

(3) Reimbursement for a custom compound drug is limited to a maximum of $600.00. Any charges exceeding this amount must be accompanied by the original component manufacturers' invoice pro-rated for each component used, for review by the carrier.

Reimbursement of biologicals, durable medical equipment and supplies.

R418.101003b

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

(2) Rented DME shall be identified on the providers' bill by RR. Modified NU will identify if the item is purchased, new.

Reimbursement of biologicals, durable medical equipment & supplies continued

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

(a) Invoice cost of $35.01 to $100.00 shall receive cost plus 50%

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

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

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

Durable Medical Equipment

R418.10913

(1) If the equipment or supply billed using an unlisted or not otherwise specified code, and the charge exceeds $35.00, than an invoice shall included with the bill.

(3) Durable medical equipment may be billed as a rental or a purchase. If possible, the provider and carrier should agree before dispensing the item as to whether it should be a rental or purchased item. With the exception of oxygen, rented DMC is considered purchased equipment once the monthly rental allowance exceeds the purchase price or payment of 12 months rental, whichever comes first.

Durable Medical Equipment continued

(a) If the worker's medical condition changes or does not improve as expected then rental may be discontinued in favor of purchase.

(b) If death occurs, rental fees for equipment will terminate as the end of the month and additional rental payment shall not be made.

(c) The return of rented equipment is the dual responsibility of the worker and the DME supplier. The carrier is not responsible and shall not be required to reimburse for additional rental periods solely because of a delay in equipment returns.

Durable Medical Equipment continued

(d) Oxygen equipment shall be considered a rental as long as the equipment is medically necessary. The equipment rental allowance includes reimbursement for the oxygen contents.

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

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

Global Surgical Procedures; Services Include

R418.10401

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

Reimbursement for "By Report" and ancillary procedures

R418.101003

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

Reimbursement for "By Report" & ancillary procedures continued

(a) Ground Ambulance Services
(b) Dental services
(c) Vision and prosthetic optical services
(d) Hearing aid services
(e) Home health services

"By Report" does not necessarily mean charges are "paid in full".

Reimbursement for Treatment of Chronic, Non-Cancer Pain with Opioids

R418.101008

*Provider may bill the additional services required for documenting compliance with these chronic opioid rules using CPT procedure code 99215 for the initial 90-day report and all follow-up reports at 90 day intervals.

*Providers may bill $25, using code MPS01, for accessing MAPS or an automated prescription drug monitoring program in the treating jurisdiction. This charge is reimbursed ONLY when part of the 90 day opioid treatment reporting.

Drug testing, drug screening, and drug confirmation testing shall use ONLY the appropriate procedure codes G0480-G0483, G0659, or 80305-80307.

Maximum of one service unit per procedure code per date of service.

*Carrier may file a 104C form with the Agency for non-compliance.

Required Opioid Documentation for Chronic, Non-Cancer Pain

R418.101008a

In order to receive reimbursement for opioid treatment beyond 90 days, the physician seeking reimbursement shall submit a report containing the following:

1) Review of relevant prior medical history/treatment, including consults or review of MAPS data, number of days since opioid treatment started, MED level, etc.
2) Summary of conservative care rendered that focused on increased function and return to work, including a statement as to why prior or alternative conservative measures were ineffective or contraindicated.
3) Review of results obtained from industry accepted screening tool to detect increased risk of abuse.
4) Treatment plan that includes:
   a) Treatment goals and functional progress.
   b) Periodic UDS.
   c) Consideration of weaning from opioids.
   d) Opioid treatment agreement which is reviewed, updated and renewed every 6 months.

Laboratory Procedure Codes and Maximum Allowable Payments

R418.101503

(1) The workers' compensation agency shall determine the maximum allowable payment for laboratory procedure codes found in the CPT and HCPCS codebooks. The rate shall be determined by multiplying the Medicare rate established for this state by 110%.

(2) The pathology procedure codes found in the 80000 series of the CPY code set have assigned relative values and shall be provided on the agency's website.

Laboratory Procedure Codes & Maximum Allowable Payments continued

(3) The maximum allowable payments for laboratory and pathology procedures shall be provided on the agency's website.

(4) A provider performing drug testing, drug screening, and drug confirmation testing shall use the appropriate procedure codes G0480-G0483, G0659 or 80305-80307 listed in the HCPCS or CPT codebook. A maximum of one service unit per procedure code per date of service shall be billed with these codes.

DRUG SCREEN CODE MAPS

Procedure Code	Description	MAP
G0480	1-7 classes	$125.87
G0481	8-14 classes	$172.25
G0482	15-21 classes	$218.61
G0483	22 or more classes	$271.61
G0659	Definitive	$79.01
80305	Presumptive-includes sample validation when performed	$14.81
80306	as above	$13.35
80307	as above	$53.44

Frequent Questions

* Services provided by non-physician (nurse practitioner, advanced practice nurse, or physician assistant) require modifier –GF and are reimbursed at 85% of the MAP, or the usual and customary charge, whichever is less. HCS Rules do not reference "Incident to" billing.

* NCCI edits – R418-10106(2) states procedure codes and standard billing and coding instructions are adopted from most recent "Current Procedural Terminology (CPT®)" adopted in the rule set. What happens if NCCI edit and CPT codebook in disagreement?

2018 Health Care Services Advisory Committee Meetings

Wednesday, May 15, 2019

Wednesday, October 23, 2019

All meetings are from 1:30p.m. to 3:30 p.m.

2501 Woodlake Circle

Okemos, MI 48864

Voicemail Messages for Facilitators

* Injured employees name, spelling the last name.
* At least the last four digits of the social security number.
* Date and time of the hearing, if known.
* Callers name and complete call back number, including any extension.

Finally, please remember…

The Workers' Compensation Agency does not handle individual claims, fee schedule bills, pay bills, authorize treatment, or issue checks.

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