DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY

WORKERS' DISABILITY COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

Filed with the secretary of state on November 1, 2021

These rules take effect immediately upon filing with the secretary of state unless adopted under section 33, 44, or 45a(9) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of state.

(By authority conferred on the workers' disability compensation agency by sections 205 and 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.205 and 418.315, section 33 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, and Executive Reorganization Order Nos. 1982-2, 1986-3, 1990-1, 1996-2, 2003-1, 2011-4, and 2019-13, MCL18.24, 418.1, 418.2, 445.2001, 445.2011, 445.2030, and 125.1998)

R 418.10101, R 418.10106, R 418.10107, R 418.10108, R 418.10116, R 418.10202, R 418.10207, R 418.10208, R 418.10901, R 418.10904, R 418.10926, R 418.101002, R 418.101003, R 418.101003a, R 418.101004, R 418.101010, R 418.101204, R 418.101206, and R 418.101303 of the Michigan Administrative Code are amended, as follows:

PART 1. GENERAL PROVISIONS

R 418.10101 Scope.

Rule 101. (1) These rules do all of the following:

(a) Establish procedures by which the employer shall furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably possible, and relieve from the effects of the injury.

(b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.

(c) Establish procedures by which a health care provider shall be paid.

(d) Provide for the identification of utilization of health care and health services above the usual range of utilization for such services, based on medically accepted standards, and provide for acquiring by a carrier and by the agency the necessary records, medical bills, and other information concerning any health care or health service under review.

(e) Establish a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.

(f) Authorize carriers to withhold or recover payment from health facilities or health care providers, that have made excessive charges or that have required unjustified treatment, hospitalization, or visits.

(g) Provide for the review by the agency of the records and medical bills of any health facility or health care provider that have been determined by a carrier not to comply with the schedule of charges established by these rules or to require unjustified treatment, hospitalization, or office visits.

(h) Provide for the certification by the agency of the carrier's professional health care review program.

(i) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health facility or health care provider may be required by the carrier to explain the necessity in writing.

(j) Provide for the interaction of the agency and the department for the utilization of departmental procedures for the resolution of workers' compensation disputes.

(k) Are intended for the implementation and enforcement of section 315(2) to (9) of the act, MCL 418.315, and provide for the implementation of the agency's review and decision responsibility vested in it by those statutory provisions. The rules and definitions are not intended to supersede or modify the workers' disability compensation act, the administrative rules of practice of the agency, or court decisions interpreting the act or the agency's administrative rules.

(2) An independent medical examination is exempt from these rules and may be requested by a carrier or an employee. An independent medical examination, (IME), shall be conducted by a practitioner other than the treating practitioner. Reimbursement for the independent medical evaluation shall be based on a contractual agreement between the provider of the independent medical evaluation and the party requesting the examination.

(3) These rules and the fee schedule do not pertain to health care services that are rendered by an employer to its employee in an employer-owned and employer-operated clinic.

(4) Payments made pursuant to a redemption order or a voluntary payment agreement signed by a magistrate, director, or director's representative are subject to these rules and fee schedule.

(5) If a carrier and a provider have a contractual agreement designed to reduce the cost of workers' compensation health care services below what would be the aggregate amount if the fee schedule were applicable, the contractual agreement shall be exempt from the fee schedule. The carrier shall do both of the following:

(a) Perform technical and professional review procedures.

(b) Provide the annual medical payment report to the agency's health care services division.

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

Rule 106. (1) Upon annual promulgation of R 418.10107, the health care services division of the agency shall provide separate from these rules a manual, tables, and charts containing all of the following information on the agency's website, www.michigan.gov/wca:

(a) All Current Procedural Terminology (CPT®) procedure codes used for billing health care services.

(b) Medicine, surgery, and radiology procedures and their associated relative value units.

(c) Hospital maximum payment ratios.

(d) Billing forms and instruction for completion.

(2) The procedure codes and standard billing and coding instructions for medicine, surgery, and radiology services is adopted from the most recent publication entitled "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107. However, billing and coding guidelines published in the CPT codebook do not guarantee reimbursement. A carrier shall only reimburse medical procedures for a work-related injury or illness that are reasonable and necessary and are consistent with accepted medical standards.

(3) The formula and methodology for determining the relative value units is adopted from the "Medicare RBRVS: The Physicians Guide" as adopted by reference in R 418.10107 using geographical information for this state. The geographical information, (GPCI), for these rules is a melded average using 60% of the figures published for the city of Detroit added to 40% of the figures published for the rest of this state.

(4) The maximum allowable payment for medicine, surgery, and radiology services is determined by multiplying the relative value unit assigned to the procedure times the conversion factor listed in the reimbursement section, part 10, of these rules.

(5) Procedure codes from "HCPCS 2021 Level II Professional Edition," as adopted by reference in R 418.10107, shall be used to describe all of the following services:

(a) Ambulance services.

(b) Medical and surgical expendable supplies.

(c) Dental procedures.

(d) Durable medical equipment.

(e) Vision and hearing services.

(f) Home health services.

(6) Medical services are considered "By Report" (BR) if a procedure code listed in "HCPCS 2021 Level II Professional Edition" or "Current Procedural Terminology (CPT®) 2021 Professional Edition" as adopted by reference in R 418.10107 does not have an assigned value.

R 418.10107 Source documents; adoption by reference.

Rule 107. The following documents are adopted by reference in these rules and are available for distribution from the indicated sources, at the cost listed in subdivisions (a) to (h) of this rule:

(a) "Current Procedural Terminology (CPT®) 2021 Professional Edition," published by the American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #EP054121, 1-800-621-8335. The publication may be purchased at a cost of $121.95

plus $16.95 shipping and handling as of the time of adoption of these rules. Permission to use this publication is on file in the workers' compensation agency.

(b) "HCPCS 2021 Level II Professional Edition," published by the American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP231521, customer service 1-800-621-8335. The publication may be purchased at a cost of $104.95, plus $16.95 for shipping and handling, as of the time of adoption of these rules.

(c) "Medicare RBRVS 2021: The Physicians' Guide," published by The American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP059621, 1-800-621-8335. The publication may be purchased at a cost of $159.95, plus $19.95 shipping and handling, as of the time of adoption of these rules.

(d) "International Classification of Diseases, ICD-10-CM 2021: The Complete Official Codebook," American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP201421, 1-800-621-8335. The publication may be purchased at a cost of $110.95, plus $16.95 shipping and handling, as of the time of adoption of these rules.

(e) "International Classification of Diseases, ICD-10-PCS 2021: The Complete Official Codebook," American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP201121, 1-800-621-8335. The publication may be purchased at a cost of $110.95, plus $16.95 shipping and handling, as of the time of adoption of these rules.

(f) Red Book® online subscription service of IBM Watson Health, contact: https://www.ibm.com/products/micromedex-red-book or IBM Watson Health, 1 New Orchard Road, Armonk, New York 10504-1722, 1-800-525-9083.

(g) Medi-Span® Drug Information Database, a part of Wolters Kluwer Health, contact: http://www.wolterskluwercdi.com or 1-855-633-0577.

(h) "Official UB-04 Data Specifications Manual 2022, July 1, 2021" adopted by the National Uniform Billing Committee, © Copyright 2021 American Hospital Association. As of the time of adoption of these rules, the cost of this eBook for a single user is $160.00 and is available at www.nubc.org.

R 418.10108 Definitions; A to I.

Rule 108. As used in these rules:

(a) "Act" means the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941.

(b) "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment to the maximum fee allowed by these rules, to a provider's usual and customary charge, or, when the maximum fee is by report, to a reasonable amount. "Adjust" also means when a carrier re-codes a procedure–or reduces payment as a result of professional review.

(c) "Agency" means the workers' disability compensation agency**.**

(d) "Ambulatory surgical center" (ASC) means an entity that operates exclusively for providing surgical services to patients not requiring hospitalization and has an agreement with the centers for Medicare and Medicaid services (CMS) to participate in Medicare.

(e) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.

(f) "Biologics" or "biologicals" include drugs or other products that are derived from life forms. Biologics are biology-based products used to prevent, diagnose, treat, or cure disease or other conditions in humans and animals. Biologics generally include products

such as vaccines, blood, blood components, allergenics, somatic cells, genes, proteins, DNA, tissues, skin substitutes, recombinant therapeutic proteins, microorganisms, antibodies, immunoglobins, and others, including, but not limited to, those that are produced using biotechnology and are made from proteins, genes, antibodies, and nucleic acids.

(g) "BR" or "by report" means that the procedure is not assigned a relative value unit, (RVU) or a maximum fee and requires a written description.

(h) "Carrier" means an organization that transacts the business of workers' compensation insurance in Michigan and that may be any of the following:

(i) A private insurer.

(ii) A self-insurer.

(iii) One of the funds in chapter 5 of the act, MCL 418.501 to 418.561.

(i) "Case" means a covered injury or illness that occurs on a specific date and is identified by the worker's name and date of injury or illness.

(j) "Case record" means the complete health care record that is maintained by a carrier and pertains to a covered injury or illness that occurs on a specific date.

(k) "Complete procedure" means a procedure that contains a series of steps that are not to be billed separately.

(l) "Covered injury or illness" means an injury or illness for which treatment is mandated by section 315 of the act, MCL 418.315.

(m) "Current Procedural Terminology (CPT®)" means a listing of descriptive terms and identifying codes and provides a uniform nationally accepted nomenclature for reporting medical services and procedures. The CPT codebook provides instructions for coding and claims processing.

(n) “Custom compound” as used in these rules, means a customized topical medication prescribed or ordered by a duly licensed prescriber for the specific patient that is prepared in a pharmacy by a licensed pharmacist in response to a licensed practitioner’s prescription or order, by combining, mixing, or altering of ingredients, but not reconstituting, to meet the unique needs of an individual patient.

(o) "Dispute" means a disagreement between a carrier or a carrier's agent and a health care provider on the application of these rules.

(p) "Durable medical equipment" means specialized equipment that is designed to stand repeated use, is used to serve a medical purpose, and is appropriate for home use.

(q) "Emergency condition" means that a delay in treating a patient would lead to a significant increase in the threat to the patient's life or to a body part.

(r) "Established patient" means a patient whose medical and administrative records for a particular covered injury or illness are available to the provider.

(s) "Expendable medical supply" means a disposable article that is needed in quantity on a daily or monthly basis.

(t) "Facility" means an entity licensed by the state pursuant to the public health code, 1978 PA 368, MCL 333.1101 to 333.25211. The office of an individual practitioner is not considered a facility.

(u) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.

(v) "Follow-up days" means the days of care following a surgical procedure that are included in the procedure's maximum allowable payment, but does not include care for

complications. The health care services division shall provide the follow-up days for surgical procedures separate from these rules on the agency's website, www.michigan.gov/wca.

(w) "Free standing outpatient facility" (FSOF) means a facility, other than the office of a physician, dentist, podiatrist, or other private practice, offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient hospital care.

(x) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes any of the following:

(i) Health maintenance organization.

(ii) Industrial or other clinic.

(iii) Occupational health care center.

(iv) Home health agency.

(v) Visiting nurse association.

(vi) Laboratory.

(vii) Medical supply company.

(viii) Community mental health board.

(y) "Health care review" means the review of a health care case or bill, or both, by a carrier, and includes technical health care review and professional health care review.

(z) "Incidental surgery" means a surgery that is performed through the same incision, on the same day, by the same doctor of dental surgery, doctor of medicine, doctor of osteopathy, or doctor of podiatry and that is not related to diagnosis.

(aa) "Independent medical examination" means an examination and evaluation that is requested by a carrier or an employee and that is conducted by a different practitioner than the practitioner who provides care.

(bb) "Industrial medicine clinic," also referred to as an "occupational health clinic," means an organization that primarily treats injured workers. The industrial medicine clinic or occupational clinic may be a health care organization as defined by these rules or may be a clinic owned and operated by a hospital for the purposes of treating injured workers.

(cc) "Insured employer" means an employer who purchases workers' compensation insurance from an insurance company that is licensed to write insurance in this state.

R 418.10116 Provider responsibilities.

Rule 116. (1) When a licensed facility or practitioner licensed in this state treats an injured worker for a compensable work-related injury or illness and bills the workers' compensation carrier, the carrier shall reimburse the licensed provider or facility the maximum allowable payment, or the providers' usual and customary charge, whichever is less, pursuant to these rules. A provider shall do both of the following:

(a) Promptly bill the carrier or the carrier's designated agent after the date of service.

(b) Submit the bill for the medical services provided to treat an injured worker on the proper claim form, to the workers' compensation carrier or the carrier's designated agent and attach the documentation required in part 9 of these rules.

(2) If the provider has not received payment within 30 days of submitting a bill, then the provider shall resubmit the bill to the carrier and add a 3% late fee.

(3) Only the provider shall alter or change in any way the provider's original bill.

PART 2. MEDICINE

R 418.10202 Evaluation and management services.

Rule 202. (1) The evaluation and management procedure codes from "Current Procedural Terminology, CPT®", as adopted by reference in R 418.10107, shall be used on the bill to describe office visits, hospital visits, and consultations. These services are divided into subcategories of new patient and established patient visits. The services are also classified according to complexity of the services. For the purposes of workers' compensation, a treating practitioner, for each new case or date of injury, shall use a new patient visit to describe the initial visit. A treating physician may not use procedures 99450 or 99455-99456 to bill for services provided to an injured worker. When a practitioner applies a hot or cold pack during the course of the office visit, the carrier is not required to reimburse this as a separate charge.

(2) Minor medical and surgical supplies routinely used by the practitioner or health care organization in the office visit shall not be billed separately. The provider may bill separately for supplies, or other services, over and above those usually incidental to the evaluation and management service using appropriate CPT® or HCPCS procedure codes.

(3) When a specimen is obtained and sent to an outside laboratory, the provider may add 99000 to the bill to describe the handling/conveyance of the specimen. The carrier shall reimburse $5.00 for this service in addition to the evaluation and management service.

(4) Appropriate procedures from "Current Procedural Terminology, CPT®" or the HCPCS Level II codebook, as adopted by reference in R 418.10107, may be billed in addition to the evaluation and management service. If an office visit is performed outside of the provider's normal business hours, the provider may bill the add on procedure code, 99050, describing an office visit performed after hours or on Sundays or holidays and shall be reimbursed $12.00 in addition to the evaluation and management. The carrier shall only reimburse the miscellaneous add-on office procedures when the services are performed outside of the provider's normal hours of business.

(5) A procedure that is normally part of an examination or evaluation shall not be unbundled and billed independently. Range of motion shall not be reimbursed as a separate procedure in addition to the evaluation and management service unless the procedure is medically necessary and appropriate for the injured worker's condition and diagnosis.

(6) The maximum allowable payment for the evaluation and management service shall be determined by multiplying the relative value unit, RVU, assigned to the procedure code, times the conversion factor listed in the reimbursement section of these rules.

(7) The level of an office visit or other outpatient visit for the evaluation and management of a patient is not guaranteed and may change from session to session. The level of service shall be consistent with the type of presenting complaint and supported by documentation in the record.

(8) When a provider bills for an evaluation and management service, a separate drug-administration charge shall not be reimbursed by the carrier, since this is considered a bundled service inclusive with the visit. The drug administration charges may be billed and paid when the evaluation and management service is not performed and billed for

a date of service. The provider shall bill the medication separate and be paid pursuant to the reimbursement provisions of these rules. The provider shall use the NDC or national drug code for the specific drug and either 99070, the unlisted drug and supply code or the specific J-code listed in HCPCS to describe the medication administered.

(9) When a provider administers a vaccine during an evaluation and management service, both the vaccine and the administration of the vaccine are billed as separate service in addition to the evaluation and management visit according to language in CPT®. Both the administration of the vaccine and the vaccine shall be reimbursed pursuant to the reimbursement provisions of these rules in addition to the visit.

(10) Procedure code 76140, x-ray consultation, shall not be paid to the provider in addition to the evaluation and management service, to review x-rays taken elsewhere. The carrier shall not pay for review of an x-ray by a practitioner other than the radiologist providing the written report or the practitioner performing the complete radiology procedure.

R 418.10207 Mental health services.

Rule 207. (1) A psychiatrist only, shall use procedure code 90792 to describe a psychiatric diagnostic evaluation with medical services, or shall use a new patient evaluation and management code instead of 90792 to describe a psychiatric diagnostic evaluation. A psychologist shall use procedure code 90791 to describe a diagnostic evaluation without medical services. Procedure codes 90791 and 90792 shall not be reported on the same day as a psychotherapy or evaluation and management service procedure code.

(2) A psychiatrist only, shall use add on procedure codes 90833, 90836 and 90838, which shall be reported in conjunction with an evaluation and management services code.

(3) An individual performing psychological testing shall report the services using procedure codes 96105-96146.

(4) Mental health providers shall use the following modifiers to describe the practitioner providing the health services:

(a) -AH, for services provided by a licensed psychologist.

(b) -AL, for services provided by a limited licensed psychologist.

(c) -AJ, for services provided by a certified social worker.

(d) -LC, for services provided by a licensed professional counselor.

(e) -CS, for services provided by a limited licensed counselor.

(f) -MF, for services provided by a licensed marriage and family therapist.

(g) -ML, for services provided by a limited licensed marriage and family therapist

R 418.10208 Vision services.

Rule 208. (1) A medical diagnostic eye evaluation by a practitioner is an integral part of all vision services.

(2) Intermediate and comprehensive ophthalmological services include medical diagnostic eye evaluation and services, such as slit lamp examination, keratometry, ophthalmoscopy, retinoscopy, tonometry, or motor evaluation. These procedures shall not be billed in conjunction with procedure codes 92002, 92004, 92012, and 92014.

(3) Only an ophthalmologist or a doctor of optometry shall use procedure codes 92002, 92004, 92012, and 92014.

(4) An employer is not required to reimburse or cause to be reimbursed charges for an optometric service unless that service is included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(5) Suppliers of vision and prosthetic optical procedures shall use the appropriate procedure code V0000-V2999 listed in the HCPCS Level II codebook, as adopted by reference in 418.10107, to describe services provided.

(6) Payment shall be made as follows for the following vision CPT codes:

(a) $50.00 for V2744, V2750, and V2760.

(b) $25.00 for V2715.

(c) $160.00 for V2020.

PART 9. BILLING
SUBPART A. PRACTITIONER BILLING

R 418.10901 General information.

Rule 901. (1) All health care practitioners and health care organizations, as defined in these rules, shall submit charges on the proper claim form as specified in this rule. Copies of the claim forms and instruction for completion for each form shall be provided separate from these rules in a manual on the workers' compensation agency's website at www.michigan.gov/wca. Charges shall be submitted as follows:

(a) A practitioner shall submit charges on the CMS1500 claim form.

(b) A doctor of dentistry shall submit charges on a standard dental claim form approved by the American Dental Association.

(c) A pharmacy, other than an inpatient hospital, shall submit charges on an invoice or an NCPDP Workers Compensation/Property & Casualty Universal Claim Form.

(d) A hospital-owned occupational or industrial clinic, or office practice shall submit charges on the CMS 1500 claim form.

(e) A hospital billing for a practitioner service shall submit charges on a CMS 1500 claim form.

(f) Ancillary service charges shall be submitted on the CMS 1500 claim form for durable medical equipment and supplies, L-code procedures, ambulance, vision, and hearing services. Charges for home health services shall be submitted on the UB-04 claim form.

(g) A shoe supplier or wig supplier shall submit charges on an invoice.

(2) A provider shall submit all bills to the carrier within 1 year of the date of service for consideration of payment, except in cases of litigation or subrogation.

(3) A properly submitted bill shall include all of the following appropriate documentation:

(a) A copy of the medical report for the initial visit.

(b) An updated progress report if treatment exceeds 60 days.

(c) A copy of the initial evaluation and a progress report every 30 days of physical treatment, physical or occupational therapy, or manipulation services.

(d) A copy of the operative report or office report if billing surgical procedure codes 10021-69990.

(e) A copy of the anesthesia record if billing anesthesia codes 00100-01999.

(f) A copy of the radiology report if submitting a bill for a radiology service accompanied by modifier -26. The carrier shall only reimburse the radiologist for the written report, or professional component, upon receipt of a bill for the radiology procedure.

(g) A report describing the service if submitting a bill for a "by report" procedure.

(h) A copy of the medical report if a modifier is applied to a procedure code to explain unusual billing circumstances.

(4) A health care professional billing for telemedicine services shall utilize procedure codes 92507, 92521-92524, 97110, 97112, 97116, 97161-97168, 97530, 97535 or those listed in Appendix P of the CPT codebook, as adopted by reference in R 418.10107, excluding CPT codes 99241-99245 and 99251-99255. The provider shall append modifier -95 to the procedure code to indicate synchronous telemedicine services rendered via 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.

R 418.10904 Procedure codes and modifiers.

Rule 904. (1) A health care service shall be billed with procedure codes adopted from "Current Procedural Terminology (CPT®) 2021 Professional Edition" or "HCPCS 2021 Level II Professional Edition," as referenced in R 418.10107. Procedure codes from the CPT code set shall not be included in these rules, but shall be provided on the workers' compensation agency’s website at www.michigan.gov/wca. Refer to "Current Procedural Terminology (CPT®) 2021 Professional Edition," as referenced in R 418.10107, for standard billing instructions, except where otherwise noted in these rules. A provider billing services described with procedure codes from "HCPCS 2021 Level II Professional Edition" shall refer to the publication as adopted by reference in R 418.10107 for coding information.

(2) The following ancillary service providers shall bill codes from "HCPCS 2021 Level II Professional Edition," as adopted by reference in R 418.10107, to describe the ancillary services:

(a) Ambulance providers.

(b) Certified orthotists and prosthetists.

(c) Medical suppliers, including expendable and durable equipment.

(d) Hearing aid vendors and suppliers of prosthetic eye equipment.

(e) A home health agency.

(3) If a practitioner performs a procedure that cannot be described by 1 of the listed CPT or HCPCS procedure codes, then the practitioner shall bill the unlisted procedure code. An unlisted procedure code shall only be reimbursed when the service cannot be properly described with a listed code and the documentation supporting medical necessity includes all of the following:

(a) Description of the service.

(b) Documentation of the time, effort, and equipment necessary to provide the care.

(c) Complexity of symptoms.

(d) Pertinent physical findings.

(e) Diagnosis.

(f) Treatment plan.

(4) The provider shall add a modifier code, found in Appendix A of the CPT codebook as adopted by reference in R 418.10107, following the correct procedure code describing unusual circumstances arising in the treatment of a covered injury or illness. When a modifier code is applied to describe a procedure, a report describing the unusual circumstances shall be included with the charges submitted to the carrier.

(5) Applicable modifiers from table 10904 shall be added to the procedure code to describe the type of practitioner performing the service. The required modifier codes for describing the practitioner are as follows:

Table 10904 Modifier Codes

-AA Anesthesia services performed personally by anesthesiologist.

-AD When an anesthesiologist provides medical supervision for more than 4 qualified individuals being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.

-AH When a licensed psychologist bills a diagnostic service or a therapeutic service, or both.

-AJ When a certified social worker bills a therapeutic service.

-AL A limited license psychologist billing a diagnostic service or a therapeutic service.

-CS When a limited licensed counselor bills for a therapeutic service.

-GF When a non-physician (nurse practitioner, advanced practice nurse, or physician assistant) provides services.

-LC When a licensed professional counselor performs a therapeutic service.

-MF When a licensed marriage and family therapist performs a therapeutic service.

-ML When a limited licensed marriage and family therapist performs a service.

-TC When billing for the technical component of a radiology service.

-QK When an anesthesiologist provides medical direction for not more than 4 qualified individuals being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.

-QX When a certified registered nurse anesthetist or certified anesthesiologist assistant performs a service under the medical direction of an anesthesiologist.

-QZ When a certified registered nurse anesthetist performs anesthesia services without medical direction.

R418.10926 Billing for air and ground ambulance services.

Rule 926. (1) Air ambulance providers shall bill procedure codes A0430, A0431, A0435, and A0436 as appropriate from the HCPCS codebook, as adopted by reference in R 418.10107.

(2) Ground ambulance providers shall bill procedure codes A0425-A0429 and A0432-A0434 as appropriate from the HCPCS codebook, as adopted by reference in R 418.10107**.**

(3) A hospital-owned air or ground ambulance provider billing with the same tax identification number as the hospital shall submit charges for ambulance services on a UB-04 form. All other ambulance providers shall submit charges for ambulance services on a CMS-1500 form.

(4) Air ambulance services are considered reasonable when a medical condition, in whole or in part, is such that transportation by either basic or advanced life support ground ambulance would constitute a threat to the patient’s life or seriously endanger the patient’s health.

(5) Ground ambulance services are considered reasonable when a medical condition is such that use of other forms of transportation are contraindicated and would endanger the patient's health.

(6) A properly submitted air or ground ambulance bill shall include documentation indicating the necessity of air or ground ambulance services.

(7) An air ambulance service shall be covered only to the nearest facility capable of furnishing the required level and type of care for the injury or illness involved.

(8) The ambulance point of pick up shall be reported by its 5-digit ZIP code. Charges for services and mileage shall be based on documented loaded patient mileage only. If the patient is pronounced dead by a legally authorized professional after the air ambulance has taken off or the ground ambulance is dispatched, but before being loaded onto the ambulance for transport, then the MAP is the appropriate base rate, with no amount allowed for mileage or for a rural adjustment.

(9) Ambulance origin and destination modifiers listed in the HCPCS Level II codebook, as adopted by reference in R 418.10107, shall be used on the bill as appropriate and will be listed on the agency website at www.michigan.gov/wca.

(10) All items and services associated with the ambulance transport are included in the maximum allowable payment and shall not be unbundled and billed separately.

(11) Ground ambulance services are reimbursed based on the level of services performed, not the type of vehicle responding.

PART 10. REIMBURSEMENT
SUBPART A. PRACTITIONER REIMBURSEMENT

R 418.101002 Conversion factors for practitioner services.

Rule 1002. (1) The agency shall determine the conversion factors for medicine, evaluation and management, physical medicine, surgery, pathology, and radiology procedures. The conversion factor shall be used by the agency for determining the maximum allowable payment for medical, surgical, and radiology procedures. The maximum allowable payment shall be determined by multiplying the appropriate conversion factor times the relative value unit assigned to a procedure. The relative value units are provided for the medicine, surgical, and radiology procedure codes separate from these rules on the agency's website, www.michigan.gov/wca. The relative value units shall be updated by the agency using codes adopted from "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107(a). The agency shall determine the relative values by using information found in the "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107(c).

(2) The conversion factor for medicine, radiology, and surgical procedures shall be $47.66 for the year 2021 and shall be effective for dates of service on or after the effective date of these rules.

R 418.101003 Reimbursement for "by report" and ancillary procedures.

Rule 1003. (1) If a procedure code does not have a listed relative value, or is noted BR, then the carrier shall reimburse the provider's usual and customary charge or reasonable payment, whichever is less, unless otherwise specified in these rules.

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

(a) Dental services.

(b) Vision and prosthetic optical services.

(c) Hearing aid services.

(d) Home health services.

(3) Orthotic and prosthetic procedures, L0000-L9999, shall be reimbursed by the carrier at Medicare plus 5%. The health care services division shall provide maximum allowable payments for L-code procedures separate from these rules on the agency's website, www.michigan.gov/wca. Orthotic and prosthetic procedures with no assigned maximum allowable payment shall be considered by report procedures and require a written description accompanying the charges on the CMS-1500 claim form. The report shall include date of service, a description of the service or services provided, the time involved, and the charge for materials and components.

R 418.101003a Reimbursement for dispensed medications.

Rule 1003a. (1) Prescription medication shall be reimbursed at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span referenced in R 418.10107, plus a dispense fee. All of the following apply.

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

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

(c) Reimbursement for repackaged pharmaceuticals shall be at a maximum reimbursement of AWP minus 10% based upon the original manufacturer's NDC number, as published by Red Book or Medi-Span, plus a dispensing fee of $3.50 for brand name and $5.50 for generic.

(d) All pharmaceutical bills submitted for repackaged products shall include the original manufacturer or distributer stock package national drug code or NDC number.

(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.

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

(3) All commercially manufactured topical medications, that do not meet the definition of "custom compound" as defined in R 418.10108, dispensed by a pharmacy or a provider shall not exceed a 30-day supply. Regardless of dispensing party, reimbursement shall be at a maximum of the acquisition cost, plus a single dispense fee. The single dispense fee

shall be $8.50 and shall be billed with WC700-T. A provider will only be reimbursed 1 dispense fee per topical medication in a 10-day period.

R 418.101004 Modifier code reimbursement.

Rule 1004. (1) Modifiers may be used to report that the service or procedure performed has been altered by a specific circumstance but does not change the definition of the code. This rule lists procedures for reimbursement when certain modifiers are used. A complete listing of modifiers are listed in Appendix A of "Current Procedural Terminology CPT® 2021 Professional Edition," and the "HCPCS 2021 Level II Professional Edition" as adopted by reference in R 418.10107.

(2) When modifier code -25 is added to an evaluation and management procedure code, reimbursement shall only be made when the documentation provided supports the patient's condition required a significant separately identifiable evaluation and management service other than the other service provided or beyond the usual preoperative and postoperative care.

(3) When modifier code -26, professional component, is used with a procedure, the professional component shall be paid.

(4) If a surgeon uses modifier code -47 when performing a surgical procedure, then anesthesia services that were provided by the surgeon and the maximum allowable payment for the anesthesia portion of the service shall be calculated by multiplying the base unit of the appropriate anesthesia code by $42.00. No additional payment is allowed for time units.

(5) When modifier code -50 or -51 is used with surgical procedure codes, the services shall be paid according to the following as applicable:

(a) The primary procedure at not more than 100% of the maximum allowable payment or the billed charge, whichever is less.

(b) The secondary procedure and the remaining procedure or procedures at not more than 50% of the maximum allowable payment or the billed charge, whichever is less.

(c) When multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body shall be reimbursed 100% of the maximum allowable payment or billed charge, whichever is less, and the second and remaining surgical procedure or procedures shall be identified by modifier code -51 and shall be reimbursed at 50% of the maximum allowable payment or billed charges, whichever is less.

(d) When modifier -50 or -51 is used with a surgical procedure with a maximum allowable payment of BR, the maximum allowable payment shall be 50% of the provider's usual and customary charge or 50% of the reasonable amount, whichever is less.

(6) The multiple procedure payment reduction shall be applied to the technical and professional component for more than 1 radiological imaging procedure furnished to the same patient, on the same day, in the same session, by the same physician or group practice. When modifier -51 is used with specified diagnostic radiological imaging procedures, the payment for the technical component of the procedure shall be reduced by 50% of the maximum allowable payment and payment for the professional component of the procedure shall be reduced to 75% of the maximum allowable payment. A table of the diagnostic imaging CPT procedure codes subject to the multiple procedure payment reduction shall be provided by the agency in a manual separate from these rules.

(7) When modifier code -TC, technical services, is used to identify the technical component of a radiology procedure, payment shall be made for the technical component only. The maximum allowable payment for the technical portion of the radiology procedure is designated on the agency's website, www.michigan.gov/wca.

(8) When modifier -57, initial decision to perform surgery, is added to an evaluation and management procedure code, the modifier -57 shall indicate that a consultant has taken over the case and the consultation code is not part of the global surgical service.

(9) When both surgeons use modifier -62 and the procedure has a maximum allowable payment, the maximum allowable payment for the procedure shall be multiplied by 25%. Each surgeon shall be paid 50% of the maximum allowable payment times 25%, or 62.5 % of the MAP. If the maximum allowable payment for the procedure is BR, then the reasonable amount shall be multiplied by 25% and be divided equally between the surgeons.

(10) When modifier code -80 is used with a procedure, the maximum allowable payment for the procedure shall be 20% of the maximum allowable payment listed in these rules, or the billed charge, whichever is less. If a maximum payment has not been established and the procedure is BR, then payment shall be 20% of the reasonable payment amount paid for the primary procedure.

(11) When modifier code -81 is used with a procedure code that has a maximum allowable payment, the maximum allowable payment for the procedure shall be 13% of the maximum allowable payment listed in these rules or the billed charge, whichever is less. If modifier code -81 is used with a BR procedure, then the maximum allowable payment for the procedure shall be 13% of the reasonable amount paid for the primary procedure.

(12) When modifier -82 is used and the assistant surgeon is a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine, or a doctor of dental surgery, the maximum level of reimbursement shall be the same as for modifier -80. If the assistant surgeon is a physician's assistant, the maximum level of reimbursement shall be the same as modifier -81. If a person other than a physician or a certified physician's assistant bills using modifier -82, then the charge and payment for the service is reflected in the facility fee.

(13) When modifier -GF is billed with evaluation and management or minor surgical services, the carrier shall reimburse the procedure at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less.

(14) When modifier -95 is used with ~~a~~ procedure code 92507, 92521-92524, 97110, 97112, 97116, 97161-97168, 97530, 97535, or those listed in Appendix P of the CPT codebook, as adopted by reference in R 418.10107, excluding CPT codes 99241-99245 and 99251-99255, the telemedicine services shall be reimbursed according to all of the following:

(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.

R418.101010 Reimbursement for air and ground ambulance services.

Rule 1010. (1) Reimbursement for air and ground ambulance services, when not provided by a hospital owned air or ground ambulance provider billing with the same tax identification number as the hospital, shall be determined by using the reimbursement rate published by CMS. The formula for determining the maximum allowable paid (MAP) for ambulance services is determined by multiplying the (Medicare rate) X (1.40). The MAP shall be published in the health care services fee schedule and shall utilize the practice expense (PE) of the geographical information (GPCI), which shall be a melded average using 60% of the figures published for the city of Detroit added to 40% of the figures published for the rest of this state.

(2) The MAP for procedure codes A0425**,** A0430, A0431, A0435, and A0436 shall list 2 values for each procedure code, an urban and a rural MAP. Reimbursement is based on the zip code at the ambulance point of pick up and based on documented loaded patient mileage only. Urban or rural designations for each zip code shall be based on CMS and indicated on the agency website at www.michigan.gov.

(3) The MAP for procedure codes A0426-A0429 and A0432-A0434 shall list 3 values for each procedure code, an urban, a rural, and a super-rural MAP. Reimbursement is based on the zip code at the ambulance point of pick up and based on documented loaded patient mileage only. Urban, rural, and super-rural designations for each zip code shall be based on CMS definitions and indicated on the agency website at www.michigan.gov.

(4) Mileage shall be reimbursed per documented loaded patient miles and is expressed in statute mile.

(a) For trips totaling up to 100 covered miles, the mileage shall be rounded up to the nearest tenth of a mile.

(b) For trips totaling 100 covered miles or greater, mileage shall be rounded up to the nearest whole number mile without use of a decimal.

(5) If the patient was pronounced dead by a legally authorized professional after the air or ground ambulance was dispatched but before the ambulance arrived at the scene, reimbursement shall be made for a fixed wing**,** rotary wing**,** or basic life support ground ambulance base rate, as applicable. Neither mileage nor a rural adjustment shall be paid. The base rate shall be indicated on the agency website at www.michigan.gov.

(6) The MAP for procedure codes A0425-A0436 includes all items, services, and supplies associated with such transport, which shall not be unbundled and billed separately.

(7) A hospital owned air or ground ambulance provider billing with the same tax identification number as the hospital shall be reimbursed based on the hospital's cost-to-charge ratio, which shall be indicated on the agency website at https://www.michigan.gov/leo/0,5863,7-336-94422_95508_26922---,00.html.

PART 12. CARRIER'S PROFESSIONAL HEALTH CARE REVIEW PROGRAM

R 418.101204 Carrier's professional health care review program.

Rule 1204. (1) A carrier may have another entity perform professional health care review activities on its behalf.

(2) The agency shall certify a carrier's professional health care review program pursuant to R 418.101206.

(3) The carrier shall submit a completed form entitled "Application for Certification of the Carrier's Professional Health Care Review Program" to the agency. If the carrier is a self-insured employer or self-insured group fund, then the service company information shall be included on the form in addition to the carrier and review company information. In addition to the completed form, the carrier shall submit all of the following:

(a) The methodology used to perform professional review.

(b) A listing of the licensed, registered, or certified health care professionals reviewing the health care bills or establishing guidelines for technical review. In addition, the proof of current licensure and qualifications for the health care professionals shall be included with the completed application.

(c) A list of the carrier's peer review staff, including specialty.

(4) The workers' compensation carrier as defined by these rules maintains full responsibility for compliance with these rules.

(5) The carrier shall determine medical appropriateness for the services provided in connection with the treatment of a covered injury or illness, using published, appropriate standard medical practices and resource documents. Utilization review shall be performed using 1 or both of the following approaches:

(a) Review by licensed, registered, or certified health care professionals.

(b) The application by others of criteria developed by licensed, registered, or certified health care professionals.

(6) The licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.

(7) The licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

(8) When peer review is utilized, a health care professional of the same specialty type as the provider of the medical service shall perform the review.

R 418.101206 Certification of professional health care review program.

Rule 1206. (1) The agency shall certify the carrier's professional health care review program.

(2) A carrier, or the reviewing entity on behalf of the carrier, shall apply to the agency for certification of a carrier's professional health care review program in the manner prescribed by the agency.

(3) A carrier shall receive certification if the carrier or the carrier's review company provides to the agency a description of its professional health care review program and includes all of the information specified in R 418.101204. The agency shall send a copy of the certification of the carrier's review program to the carrier.

(4) The carrier shall submit to the agency for approval a copy of "The Carriers Explanation of Benefits" form utilized to notify providers of payment decisions.

R 418.101303 Provider's request for reconsideration of bill; carrier's response to provider's right to appeal.

Rule 1303. (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. The carrier’s notification shall include an explanation of the appeal process provided under these rules, including the fact that any requested administrative appeal hearing shall be conducted by a director’s representative, a magistrate, or both**.**

(2) If a provider disagrees with the action taken by the carrier on the provider's request for reconsideration, then a provider may file an application for mediation or hearing with the agency. A provider shall send its application for mediation or hearing to the agency within 30 days from the date of receipt of a carrier's denial of the provider's request for reconsideration. The provider shall send a copy of the application to the carrier.

(3) If, within 60 days of the provider's request for reconsideration, the provider does not receive payment for the adjusted or rejected bill or a portion of the bill, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may apply for mediation or hearing. The provider shall send the application for mediation or hearing to the agency and shall send a copy to the carrier.