DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY

WORKERS' DISABILITY COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

(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)

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.

History: 1998-2000 AACS; 2005 AACS; 2012 AACS; 2021 AACS.

R 418.10102 Claim filing limitations.

Rule 102. (1) A provider shall bill a carrier within one year of the date of service for consideration of payment.

(2) The one year filing rule shall not apply if the provider bills after the one year requirement under subrule (1) of this rule due to litigation or subrogation.

History: 1998-2000 AACS.

R 418.10103 Rescinded.

History: 1998-2000 AACS; 2005 AACS; 2015 AACS.

R 418.10104 Reimbursement to injured worker or to health insurer for compensable medical services.

Rule 104. (1) Notwithstanding any other provision of these rules, if an injured worker has paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the injured worker shall be fully reimbursed by the carrier.

(2) The injured worker may submit the request for reimbursement on a medical or dental claim form, but shall supply to the carrier a copy of a statement including the provider name, the date of service, the procedure and diagnosis and documentation of the amount paid.

(3) When a health insurer pays for a medical service to treat an injured worker and subsequently requests reimbursement from the workers' compensation carrier, the health insurer is not required to submit the request on a CMS 1500, or a UB-04 claim form, or other medical or dental claim form. The health insurer shall supply to the workers' compensation carrier, or the carrier's designee, a claim detail showing the date of service, the amount billed and paid, the procedure code and diagnosis for the rendered services.The workers' compensation carrier shall reimburse the health insurer the provider's usual and customary fee or the maximum allowable fee, whichever is less, for the compensable medical services in accordance with these rules.If the health insurer reimbursed the provider less than the amount allowed by these rules, then the workers' compensation carrier shall reimburse the amount paid by the health insurer.

History: 1998-2000 AACS; 2003 AACS; 2005 AACS; 2008 AACS.

R 418.10105 Balance billing amounts in excess of fees.

Rule 105. The provider shall not bill the injured worker for any amount for health care services, or for late fees incurred, provided for the treatment of a covered injury or illness when the 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.

History: 1998-2000 AACS; 2003 AACS.

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/leo/bureaus-agencies/wdca:

(a) All Current Procedural Terminology (CPT®) procedure codes used for billing healthcare 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 are adopted from the most recent publication titled "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), 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 by the conversion factor listed in the reimbursement section, part 10, of these rules.

(5) Procedure codes from "HCPCS 2023 Level II Professional Edition," as adopted by reference in R 418.10107, must 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 2023 Level II Professional Edition” or “Current Procedural Terminology (CPT®) 2023 Professional Edition,” as adopted by reference in R 418.10107, does not have an assigned value.

History: 1998-2000 AACS; 2003 AACS; 2004 AACS; 2014 AACS; 2017 AACS; 2018 AACS; 2019 AACS; 2021 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

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®) 2023 Professional Edition,” published by the American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #EP054123, 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amastore.com. The list price is $134.95 at the time of adoption of these rules. Permission to use this publication is on file in the agency.

(b) "HCPCS 2023 Level II Professional Edition,” published by the American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP231523, customer service 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amastore.com. The list price is $106.95 at the time of adoption of these rules.

(c) "Medicare RBRVS 2023: The Physicians' Guide," published by The American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP059623, 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amamstore.com. The list price is $159.95 at the time of adoption of these rules.

(d) “International Classification of Diseases, ICD-10-CM 2023: The Complete Official Codebook,” American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935,

item #OP201423, 1-800-621-8335. The publication may be purchased through the AMA's website at www.amamstore.com. The list price is $112.95 at the time of adoption of these rules.

(e) "International Classification of Diseases, ICD-10-PCS 2023: The Complete Official Codebook," American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935 item #OP201123, 1-800-621-8335. The publication may be purchased through the AMA's website at www.amastore.com. The list price is $112.95 at the time of adoption of these rules.

(f) Merative™ Micromedex® Red Book® online subscription service of Merative, which can be purchased at https://www.ibm.com/products/micromedex-red-book or from Merative, 100 Phoenix Drive, Ann Arbor, Michigan 48108, 1-800-525-9083.

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

(h) "Official UB-04 Data Specifications Manual 2023, July 1, 2022" adopted by the National Uniform Billing Committee, © Copyright 2022 American Hospital Association. As of the time of adoption of these rules, the cost of this eBook for a single user is $170.00 and is available at www.nubc.org.

History: 1998-2000 AACS; 2001 AACS; 2002 AACS; 2003 AACS; 2004 AACS; 2005 AACS; 2006 AACS; 2006 AACS; 2007 AACS; 2008 AACS; 2009 AACS; 2010 AACS; 2012 AACS; 2014 AACS; 2017 AACS; 2018 AACS; 2019 AACS; 2021 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.10108 Definitions; A to I.

Rule 108. As used in these rules:

(a) "Acquisition cost" means the provider's purchase cost established by an invoice detailing the line-item cost to the provider from a manufacturer or wholesaler net of any rebates or discounts.

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

(c) "Adjust" means that a carrier or a carrier's agent reduces a healthcare 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.

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

(e) "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.

(f) "Appropriate care" means healthcare that is suitable for a particular individual, condition, occasion, or place.

(g) "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.

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

(i) "Carrier" means an organization that transacts the business of workers' compensation insurance in this state 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.

(iv) The Christopher R. Slezak first responder presumed coverage fund.

(j) "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.

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

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

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

(n) "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.

(o) “Custom compound” 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.

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

(q) "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.

(r) "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.

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

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

(u) "Facility" means an entity licensed by this 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.

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

(w) "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/leo/bureaus-agencies/wdca.

(x) "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.

(y) "Healthcare organization" means a group of practitioners or individuals joined together to provide healthcare services and includes any of the following:

(i) Health maintenance organization.

(ii) Industrial or other clinic.

(iii) Occupational healthcare center.

(iv) Home health agency.

(v) Visiting nurse association.

(vi) Laboratory.

(vii) Medical supply company.

(viii) Community mental health board.

(z)"Healthcare review" means the review of a healthcare case or bill, or both, by a carrier, and includes technical healthcare review and professional healthcare review.

(aa) "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, that is not related to diagnosis.

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

(cc) "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 health clinic may be a healthcare organization or may be a clinic owned and operated by a hospital for the purposes of treating injured workers.

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

History: 2000 AACS; 2001 AACS; 2003 AACS; 2005 AACS; 2010 AACS; 2012 AACS; 2014 AACS; 2017 AACS; 2021 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.10109 Definitions; M to U.

Rule 109. As used in these rules:

(a) "Maximum allowable payment" means the maximum fee for a procedure that is established by these rules, a reasonable amount for a "by report" procedure, or a provider's usual and customary charge, whichever is less.

(b) "Medical only case" means a case that does not involve wage loss compensation.

(c) "Medical rehabilitation" means, to the extent possible, the interruption, control, correction, or amelioration of a medical or a physical problem that causes incapacity through the use of appropriate treatment disciplines and modalities that are designed to achieve the highest possible level of post-injury function and a return to gainful employment.

(d) "Medically accepted standards" means a measure that is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services ensuring that the health care is suitable for a particular person, condition, occasion, or place.

(e) "Morbidity" means the extent of illness, injury, or disability.

(f) "Mortality" means the likelihood of death.

(g) "New patient" means a patient who is new to the provider for a particular covered injury or illness and who needs to have medical and administrative records established.

(h) "Nursing home" means a nursing care facility, including a county medical care facility, created pursuant to section 20109 of the public health code, 1978 PA 368, MCL 333.20109.

(i) “Opioid drugs” as used in these rules, refers to opiate analgesics, narcotic analgesics, or any other Schedule C (II-III) controlled substance as identified in United States Code Controlled Substances Act of 1970, 21. U.S.C. §812. Opioid analgesics are the class of drugs, such as morphine, codeine, and methadone, that have the primary indication for the relief of pain.

(j) "Orthotic equipment" means an orthopedic apparatus that is designed to support, align, prevent, or correct deformities of, or improve the function of, a movable body part.

(k) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

(l) "Practitioner" means an individual who is licensed, registered, or certified as used in the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(m) "Primary procedure" means the therapeutic procedure that is most closely related to the principal diagnosis and has the highest assigned relative value unit (RVU).

(n) "Properly submitted bill" means a request by a provider for payment of health care services that is submitted to a carrier on the appropriate completed claim form with attachments as required by these rules.

(o) "Prosthesis" means an artificial substitute for a missing body part. A prosthesis is constructed by a "prosthetist", a person who is skilled in the construction and application of a prosthesis.

(p) "Provider" means a facility, health care organization, or a practitioner.

(q) "Reasonable amount" means 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 workers' compensation agency, health care services division.

(r) "Restorative" means that the patient's function will demonstrate measurable improvement in a reasonable and generally predictable period of time and includes appropriate periodic care to maintain the level of function.

(s) "Secondary procedure" means a surgical procedure that is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.

(t) "Separate procedure" means procedures or services listed in the CPT code set that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of a term "separate procedure."

(u) "Specialist" means any of the following entities that are board-certified, board-eligible, or otherwise considered an expert in a particular field of health care by virtue of education, training, and experience generally accepted in that particular field:

(i) A doctor of chiropractic.

(ii) A doctor of dental surgery.

(iii) A doctor of medicine.

(iv) A doctor of optometry.

(v) A doctor of osteopathic medicine and surgery.

(vi) A doctor of podiatric medicine and surgery.

(v) "Subrogation" means substituting 1 creditor for another. An example of subrogation in workers' compensation is when a case is determined to be workers' compensation and the health benefits plan has already paid for the service and is requesting the workers' compensation carrier or the provider to refund the money that the plan paid on behalf of the worker.

(w) "Technical surgical assist" means that additional payment for an assistant surgeon, referenced in R 418.10416, is allowed for certain designated surgical procedures.

(x) “Telemedicine” means the 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 the patient via a 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.

(y) "Treatment plan" means a plan of care for restorative physical treatment services that indicates the diagnosis and anticipated goals.

(z) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges which were previously billed separately and which are included in the package for that procedure as defined by these rules. A usual and customary charge for a procedure shall be calculated based on data beginning January 1, 2000.

(aa) “Utilization review” means the initial evaluation by a carrier of the appropriateness in terms of both the level and the quality of health care and health services provided an injured employee, based on medically accepted standards.

History: 1998-2000 AACS; 2004 AACS; 2005 AACS; 2009 AACS; 2010 AACS; 2014 AACS; 2017 AACS; 2019 AACS.

R 418.10110 Rescinded.

History: 1998-2000 AACS; 2005 AACS; 2015 AACS.

R 418.10111 Advisory committee.

Rule 111. The director of the workers' compensation agency shall appoint an advisory committee from names solicited from provider, carrier, and employee organizations. The advisory committee shall include 5 advocates for the concerns of providers, 5 advocates for the concerns of employees, and 5 advocates for the concerns of carriers. The director of the workers' compensation agency shall appoint a sixteenth member to act as chair without a vote. The advisory committee shall meet not less than twice a year. Additional meetings shall be scheduled if requested by the workers' compensation agency, the chair, or a majority of the committee. Members may be removed by the director of the workers' compensation agency for cause or for missing more than one-half of the meetings in a year. The advisory committee shall perform general program oversight and assist the workers' compensation agency with the following:

(a) Annual review of the rules and the fee schedule.

(b) Development of proposed amendments to the rules and fee schedule, including payment methodologies.

(c) Review of data reports and data analyses.

History: 1998-2000 AACS; 2005 AACS; 2017 AACS.

R 418.10112 Missed appointment.

Rule 112. A provider shall not receive payment for a missed appointment unless the appointment was arranged by the carrier or the employer. If the carrier or employer fails to cancel the appointment not less than 72 hours in advance and the provider is unable to arrange for a substitute appointment for that time, then the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of BR.

History: 1998-2000 AACS.

R 418.10113 Initial evaluation and management service; medical report other than inpatient hospital care.

Rule 113. (1) Except as provided in subrule (2) of this rule, and for other than inpatient hospital care, a provider shall furnish the carrier, at no additional charge, with a medical report for the initial visit, all information pertinent to the covered injury or illness if requested at reasonable intervals, and a progress report for every 60 days of continuous treatment for the same covered injury or illness.

(2) If the provider continues to treat an injured or ill employee for the same covered injury or illness at intervals which exceed 60 days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 days.

(3) The medical report of the initial visit and the progress report shall include all of the following information:

(a) Subjective complaints and objective findings, including interpretation of diagnostic tests.

(b) For the medical report of the initial visit, the history of the injury, and for the progress report, significant history since the last submission of a progress report.

(c) The diagnosis.

(d) As of the date of the medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment.

(e) Physical limitations.

(f) Expected work restrictions and length of time if applicable.

History: 1998-2000 AACS.

R 418.10114 Requests for existing medical records and reports.

Rule 114. (1) Nothing in these rules shall preclude a carrier, a carrier's agent, an employee, or an employee's agent from requesting additional existing medical records and reports related to a specific date of injury, in addition to those specified in R 418.10113, or those required for proper submission of a bill from a provider.

(2) If a provider is requested by the carrier to prepare and submit a special written report in addition to the medical records required by R 418.10113, R 418.10203, R 418.10204, and

R 418.10901, then 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.

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

History: 1998-2000 AACS.

R 418.10115 Responsibilities of insured employer or self-insurer.

Rule 115. (1) An insured employer shall do all of the following:

(a) Promptly file form 100, employer's basic report of injury, to report an injury that results in 7 or more days of disability, specific loss, or death, with the workers' compensation agency and its insurer.

(b) Promptly notify its insurer of the cases that do not result in 7 or more days of disability, specific loss, or death.

(c) Promptly inform the provider of the name and address of its insurer or the designated agent of the insurer to whom health care bills should be sent.

(d) If an insured employer receives a bill, then the insured employer shall promptly transmit the provider's bill and documentation to the insurer or the designated agent of the insurer regarding a related injury or illness.

(2) For the purposes of this rule, a self-insurer shall promptly report all employee work-related injuries to their designated agent, unless they are self-administered.

(a) Unless self-administered, a self-insurer receiving a bill for a medical service shall forward the bill to their designated agent for processing and shall inform the medical provider of the address where future bills shall be sent.

History: 1998-2000 AACS; 2002 AACS; 2005 AACS.

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.

History: 1998-2000 AACS; 2002 AACS; 2003 AACS; 2021 AACS.

R 418.10117 Carrier responsibilities.

Rule 117. (1) The carrier or its designated agent shall assure that a billing form is completed properly before making payment to the licensed provider or licensed facility.

(2) A carrier may designate a third party to receive provider bills on its behalf. If a carrier instructs the provider to send the medical bills directly to the third party, then the 30-day limit of this rule begins when the third party receives the bill. The carrier is responsible for forwarding bills and medical documentation when there is a third party reviewing medical bills for the carrier.

(3) A carrier or designated agent shall make payment of an unadjusted and properly submitted bill within 30 days of receipt of a properly submitted bill or shall add a self-assessed 3% late penalty to the maximum allowable payment or the provider's charge, whichever is less, as required by these rules.

(4) A carrier or designated agent shall record payment decisions on a form entitled "Carrier's Explanation of Benefits" using a format approved by the workers' compensation agency. The carrier or designated agent shall keep a copy of the explanation of benefits and shall send a copy to the provider and to the injured worker. The carrier's explanation of benefits shall list a clear reason for the payment adjustment or amount disputed and shall notify the provider what information is required for additional payment.

(5) A carrier or designated agent shall make payment of an adjusted bill or portion of an adjusted bill within 30 days of receipt of the properly submitted bill. If a carrier or designated agent rejects a bill in its entirety, then the carrier or designated agent shall notify the provider of the rejection within 30 days after receipt of a properly submitted bill.

(6) If a carrier requests the provider to send duplicated copies of the documentation required in part 9 or additional medical records not required by these rules, then the carrier shall reimburse the provider for the copying charges in accord with R 418.10118.

(7) When the carrier has disputed a case and has not issued a copy of the formal notice of dispute to the medical provider, then the carrier's explanation of benefits shall be sent in response to the provider's initial bill. The carriers' explanation of benefits shall serve as notice to the provider that nonpayment of the bill is due to the dispute.

History: 1998-2000 AACS; 2002 AACS; 2003 AACS; 2005 AACS; 2009 AACS; 2019 AACS.

R 418.10118 Practitioner, facility, and health care organization copying charge for medical records.

Rule 118. (1) A practitioner, facility, or health care organization shall, at the request of the carrier, the carrier's agent, the employee, or the employee's agent, furnish copies of the case record for a particular covered injury or illness to the carrier, the carrier's agent, the employee, or the employee's agent. The maximum fee for providing copies shall be 45 cents per page, plus the actual cost of mailing. In addition, an administration charge for the staff's time to retrieve and copy the records shall be paid as follows:0-15 minutes $2.50 Each additional 15 minute increment $2.50The copying and handling charge shall apply to all reports and records, other than the original copy required pursuant to the provisions of R 418.10113, and all other reports required by these rules. The party who requests the records shall pay the copying charge.

(2) The copying charge for each x-ray film requested by the carrier or the carrier's agent shall be reimbursed at $15.00, which includes mailing and handling.

(3) If an agent of a carrier or an employee requests a copy of the case record, then the agent shall indicate the date of injury. Only the records for a specific date of injury covered by the act and these rules are available as specified in subrule (1) of this rule.

History: 1998-2000 AACS; 2005 AACS.

R 418.10119 Rescinded.

History: 1998-2000 AACS; 2017 AACS.

R 418.10120 Recovery of payment.

Rule 120. (1) Nothing in this rule shall preclude the recovery of payment for services and bills which may later be found to have been medically inappropriate or paid at an amount that is more than the maximum allowable payment.

(2) If the carrier makes a request to the provider for the recovery of a payment within 1 year of the date of payment and includes a statement of the reasons for the request, then the carrier may recover a payment. The carrier may recover a payment made by an employee or the carrier.

(3) Within 30 days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:

(a) If the provider is in agreement with the request, then the provider shall refund the payment to the carrier.

(b) If the provider is not in agreement with the request, then the provider shall supply the carrier with a written detailed statement of the reasons for its disagreement, together with a refund of the portion, if any, of the payment that the provider agrees should be refunded.

(4) If the carrier does not accept the reason for disagreement supplied by the provider, then the carrier may file an application for mediation or hearing as provided for in R 418.101303 and R 418.101304. Within 30 days of receipt of the provider's statement of disagreement, the carrier shall file the application for mediation or hearing with the workers' compensation agency and the carrier shall mail a copy to the provider.

(5) If, within 60 days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:

(a) File an application for mediation or hearing and mail a copy to the provider.

(b) Reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment.

(6) If, within 30 days of a final order of a magistrate, the appellate commission, or the courts, a provider does not pay in full any refund ordered, then the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment.

History: 1998-2000 AACS; 2005 AACS.

R 418.10121 Rehabilitation nurse or nurse case manager visits; additional services.

Rule 121. (1) If a carrier assigns a rehabilitation nurse or nurse case manager to an injured worker's case, and the carrier requires that the nurse accompany the injured worker to provider visits, then the carrier shall reimburse the provider for the additional time.

(2) 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 RN001.

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

History: 1998-2000 AACS; 2003 AACS.

PART 2. MEDICINE

R 418.10201 Medicine services; description.

Rule 201. Medicine services shall be described with procedure codes 90281-99199.

History: 1998-2000 AACS.

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.

History: 1998-2000 AACS; 2002 AACS; 2003 AACS; 2004 AACS; 2007 AACS; 2017 AACS; 2021 AACS.

R 418.10203 Office visit or other outpatient visit for evaluation and management of patient in conjunction with ongoing osteopathic manipulative treatment or chiropractic manipulative treatment.

Rule 203. (1) The carrier shall reimburse for the initial evaluation and management examination billed by the provider before initiating chiropractic or osteopathic manipulation. The carrier shall also reimburse for osteopathic manipulative treatment or chiropractic manipulative treatment if the treatment is initiated on the same date of service.

(2) All of the following provisions apply to ongoing osteopathic manipulative treatment:

(a) Osteopathic manipulative treatment procedure codes include pre-manipulative patient evaluation. The physician may bill a separate evaluation and management service using modifier code -25. The carrier shall only reimburse the service if the documentation provided supports significant change of signs and symptoms or the evaluation of another

work related problem not included in the procedure or service that required the encounter. The physician shall document the rationale for the significant other service in the record.

(b) Osteopathic manipulations are to be billed using procedure codes 98925-98929.

(3) All of the following provisions apply to ongoing chiropractic manipulative treatment:

(a) The chiropractic manipulative treatment codes include a pre-manipulation patient evaluation. The provider may report a separate evaluation and management service using modifier -25 to designate a separate identifiable service. The carrier shall reimburse the evaluation and management service only when the provider documents significant change of signs and symptoms or the evaluation of another work related problem not included in the procedure or service that required the encounter. The provider shall document the rationale for the significant other service in the record. (b) The carrier shall reimburse chiropractic manipulative treatment when the provider bills the service with procedure codes 98940-98942.

(4) If either a doctor of osteopathy or a doctor of chiropractic, conducts a periodic re-evaluation, then a report of the evaluation shall accompany the bill. A periodic re-evaluation report shall include all of the following information:

(a) A description of the evaluation of function in measurable terms based on physical findings and problem identification.

(b) A goal statement.

(c) A treatment plan.

(d) Physical and functional improvement in measurable terms that has occurred in relationship to the diagnosis for which the treatment was prescribed.

(e) The likelihood of continued improvement if treatment is continued.

History: 1998-2000 AACS.

R 418.10204 Office visit or other outpatient visit; evaluation and management of patient's progress in physical treatment.

Rule 204. (1) An office visit or other outpatient visit for the evaluation and management of a patient's progress in physical treatment shall only be billed when there is a change of signs or symptoms and when the referring or treating practitioner provides supporting documentation as described in subrule (2) of this rule. The supporting documentation shall indicate that it is medically appropriate for the practitioner to make the evaluation. (2) Documentation shall include the referring or treating practitioner's statement that an office visit was medically necessary. In addition, a report shall state that an examination was conducted and shall set forth the specific findings by the practitioner, including all of the following:

(a) A description of the evaluation of function in measurable terms based on physical findings and problem identification.

(b) A goal statement.

(c) A treatment plan.

(d) Physical and functional improvement in measurable terms that has occurred in relationship to the diagnosis for which physical medicine treatment was prescribed.

(e) The likelihood of continued improvement if physical medicine treatment were continued.

(3) The report required pursuant to subrule (2) of this rule may be used to meet the reporting requirements of physical medicine services provided in these rules.

(4) The office visit or other outpatient visit for the evaluation and management of a patient shall include the evaluation procedures that are appropriate to the diagnosis.

(5) Nothing in this rule pertains to office visits or other outpatient visits for the evaluation and management of a patient that are not related to physical treatment.

History: 1998-2000 AACS.

R 418.10205 Consultation services.

Rule 205. (1) An attending physician, carrier, third-party administrator, or the injured worker may request a consultation. Codes 99241-99245 and 99251-99255 shall not be used for consultation examinations. Providers shall use the evaluation code that most accurately reflects the service rendered.

(2)If a specialist performs diagnostic procedures or testing in addition to the evaluation, then the specialist shall bill the appropriate procedure code from "Physicians' Current Procedural Terminology (CPT®). The carrier shall reimburse the testing procedures in accordance with these rules.

History: 2000 AACS; 2002 AACS; 2010 AACS.

R 418.10206 Emergency department evaluation and management visit.

Rule 206. An emergency physician shall use emergency department evaluation and management service procedure codes to report an emergency department visit.

History: 1998-2000 AACS.

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

History: 2000 AACS; 2001 AACS; 2014 AACS; 2018 AACS; 2021 AACS.

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.

History: 1998-2000 AACS; 2012 AACS; 2018 AACS; 2021 AACS.

R 418.10209 Hearing services.

Rule 209. (1) A provider performing a comprehensive otorhinolaryngologic evaluation shall report the service using the appropriate evaluation and management service.

(2) A provider shall not report an otoscope, a rhinoscopy, or a tuning fork test in addition to a comprehensive ear evaluation or office visit.

(3) A provider performing special otorhinolaryngologic procedures, in addition to the evaluation, shall report those services using procedure codes 92502-92700.

(4) An audiologist, speech therapist, and a speech and hearing center shall use appropriate procedure codes from "Current Procedural Terminology, (CPT®)" or the HCPCS Level II codebook, as adopted by reference in R 418.10107, to describe services provided.

(5) Hearing aid suppliers shall use the appropriate procedure code listed in the HCPCS Level II codebook, as adopted by reference in R 418.10107 to describe services provided.

(6) When requesting payment for hearing aids a minimum of 2 comparable written quotations shall be required for hearing aids that exceed $1,500 per hearing aid, including related services such as orientation, fitting, ear molds, support, adjustment, conformity check, batteries, warranties and follow-up. Only a single price quotation shall be required for hearing aids, including related services, that cost $1,500 or less per hearing aid.

History: 1998-2000 AACS; 2012 AACS; 2017 AACS.

R 418.10212 Physical and occupational therapy; physical medicine services; physical treatment.

Rule 212. (1) For the purposes of workers' compensation, physical medicine services, procedure codes 97010-97799, shall be referred to as "physical treatment" when the services are provided by a practitioner other than a physical therapist or an occupational therapist. Physical therapy means physical treatment provided by a licensed physical therapist. Occupational therapy means physical treatment provided by an occupational therapist.

(2) Physical medicine services shall be restorative. If documentation does not support the restorative nature of the treatment, then the service shall not be reimbursed.

(3) Any of the following may provide physical treatment, to the extent that licensure, registration, or certification law allows:

(a) A doctor of medicine.

(b) A doctor of osteopathic medicine and surgery.

(c) A doctor of dental surgery.

(d) A doctor of chiropractic.

(e) A doctor of podiatric medicine and surgery.

(f) A physical therapist.

(g) An occupational therapist.

(4) Only a licensed physical therapist, licensed occupational therapist, or licensed practitioner may use procedure codes 97161-97168 to describe the physical medicine and rehabilitation evaluation services. Job-site evaluations may be paid to a licensed occupational therapist, a licensed physical therapist, or a physician. Job-site evaluations for workers' compensation are by report and are described on the bill using codes WC500-WC600.

(5) If a practitioner performs and bills for physical treatment, then the practitioner shall do all of the following:

(a) Perform an initial evaluation.

(b) Develop a treatment plan.

(c) Modify the treatment as necessary.

(d) Perform a discharge evaluation. The practitioner shall provide the carrier with an initial evaluation and a progress report every 30 calendar days and at discharge. Documentation requirements are the same as the requirements in R 418.10204(2).

(6) A provider shall report procedure code 97750 to describe a functional capacity evaluation. The carrier shall reimburse a maximum of 24 units or 6 hours for the initial evaluation. Not more than 4 additional units shall be billed for a re-evaluation occurring within 2 months.

(7) Physical medicine modalities are those agents applied to produce therapeutic changes to tissue and include, but are not limited to, thermal, acoustic, light, mechanical, or electric energy. Both of the following apply:

(a) Supervised modalities include procedure codes 97010-97028. These codes do not require direct 1-on-1 patient contact by the provider. These modalities shall be performed in conjunction with a therapeutic procedure including manipulative services or the modalities shall not be reimbursed.

(b) Constant attendance modalities are those procedure codes 97032-97039 that require direct 1-on-1 patient contact by the provider.

(8) Therapeutic procedure codes 97110-97546 are procedures that effect change through the application of clinical skills and services that attempt to improve function. The physician or therapist shall have direct 1-on-1 patient contact.

(9) The following provisions apply to the listed modality services:

(a) Whirlpool shall only be reimbursed when done for debridement or as part of a restorative physical treatment program.

(b) Procedure 97010 is a bundled procedure code and shall not be reimbursed separately.

(c) Not more than 1 deep heat procedure shall be billed on the same date of service for the same diagnosis. Deep heat procedures include diathermy, microwave, ultrasound, and phonophoresis.

(d) Phonophoresis shall be billed using procedure code 97035 with modifier code -22 and shall be reimbursed at the same rate as procedure code 97035, plus $2.00 for the active ingredient used in the process.

(e) Iontophoresis shall include the solution, medication, and the electrodes.

(f) Electrical stimulation shall include the electrodes.

(g) Procedure codes 97032, 97033, and 97035 shall not be reimbursed to a doctor of chiropractic.

(h) Fluidotherapy, a dry whirlpool treatment, shall be reported using code 97022.

History: 1998-2000 AACS; 2006 AACS; 2009 AACS; 2010 AACS; 2018 AACS.

R 418.10213 Rescinded.

History: 1998-2000 AACS; 2009 AACS.

R 418.10214 Orthotic and prosthetic equipment.

Rule 214. (1) A copy of a prescription by 1 of the following is required for prosthetic and orthotic equipment:

(a) A doctor of medicine.

(b) A doctor of osteopathic medicine and surgery.

(c) A doctor of chiropractic.

(d) A doctor of podiatric medicine and surgery.

(2) Orthotic equipment may be any of the following:

(a) Custom-fit.

(b) Custom-fabricated.

(c) Non-custom supply that is prefabricated or off-the-shelf.

(3) A non-custom supply shall be billed using procedure code 99070, appropriate L-codes or A4570 for a prefabricated orthosis.

(4) An orthotist or prosthetist that is certified by the American board for certification in orthotics and prosthetics shall bill orthosis and prostheses that are custom-fabricated, molded to the patient, or molded to a patient model. Licensed physical and licensed occupational therapists may bill orthoses using L-codes within their discipline's scope of practice. In addition, a doctor

of podiatric medicine and surgery may bill for a custom fabricated or custom-fit, or molded patient model foot orthosis using procedure codes L3000-L3649.

(5) If a licensed occupational therapist or licensed physical therapist constructs an extremity orthosis that is not adequately described by another L-code, then the therapist shall bill the service using an unlisted or “not otherwise specified” L-code.The carrier shall reimburse this code as a "by report" or "BR" procedure. The provider shall include the following information with the bill:

(a) A description of the orthosis.

(b) The time taken to construct or modify the orthosis.

(c) The charge for materials, if applicable.

(6) L-code procedures shall include fitting and adjustment of the equipment.

(7) The health care services division shall provide the maximum allowable payments for L-code procedures separate from these rules on the agency’s website, www.michigan.gov/wca. If an L-code procedure does not have an assigned maximum allowable payment, then the procedure shall be by report, "BR."

(8) A provider may not bill more than 4 dynamic prosthetic test sockets without documentation of medical necessity. If the physician's prescription or medical condition requires utilization of more than 4 test sockets, then a report shall be included with the bill that outlines a detailed description of the medical condition or circumstances that necessitate each additional test socket provided.

History: 2000 AACS; 2004 AACS; 2009 AACS; 2010 AACS; 2014 AACS; 2018 AACS.

PART 4. SURGERY

R 418.10401 Global surgical procedure; services included.

Rule 401. (1) The surgical procedures in the CPT code set as adopted in R 418.10107 always include the following list of specific services in addition to the surgical procedure.

(a) Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia.

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

(c) Immediate postoperative care, including dictating operative notes, talking with the family and other physicians.

(d) Writing postoperative surgical orders in the patient's chart and dictating an operative report.

(e) Evaluating the patient in the postanesthesia recovery area.

(f) Typical, routine, normal postoperative follow-up care, including suture removal, during the global period. The global period or follow-up days shall be provided separate from the rules on the agency website, www.michigan.gov/wca.

(2) Intra-operative procedures required to perform the surgical service shall not be billed separately.

History: 1998-2000 AACS; 2007 AACS; 2014 AACS.

R 418.10403 Complication, exacerbation, recurrence, or presence of other disease or injury.

Rule 403. (1) If a complication, exacerbation, recurrence, or the presence of other disease or injury exists that requires additional services, then the services shall be reported and identified by the appropriate procedure code.

(2) Reimbursement shall only be made for services related to, or resulting from, the covered work injury.

History: 1998-2000 AACS.

R 418.10404 Follow-up care occurring during global service.

Rule 404. (1) Follow-up care for a diagnostic procedure shall refer only to the days required to recover from the diagnostic procedure and not the treatment of the underlying condition.

(2) Follow-up care for therapeutic surgical procedures includes only that care that is usually part of the surgical service. Complications, exacerbations, recurrence, or the presence of other compensable diseases or injuries requiring additional services should be reported with the identification of appropriate procedures. The follow-up days for the surgical procedures are adopted from the "Medicare RBRVS: The Physicians Guide," as referenced in R 418.10107. The follow-up days for each surgical procedure are provided separate from these rules on the agency website, www.michigan.gov/wca. All of the following apply to the global service provider:

(a) If a carrier requests the surgeon to see an injured worker during the global service period for the purpose of job restrictions, job adjustments, or return to work, then the visit shall not be considered part of the global surgery package. If the carrier requests the visit, then the carrier shall prior authorize the visit assigning an authorization number. The provider shall bill the visit using procedure 99455 and modifier -32, including the authorization number in box 23 of the CMS 1500 form. The carrier shall not deny a prior authorized visit and shall reimburse the provider for the prior authorized visit. The maximum allowable payment for 99455-32 shall be listed in the manual published separate from these rules.

(b) The medical record shall reflect job adjustments, job restrictions or limitations, or return to work date, and the provider shall include the medical record with the bill.

(c) If an insured employer requests the surgeon to see an injured worker during the global surgery period for the purpose of job adjustments, restrictions, or return to work, then the employer shall obtain the prior authorization number from the carrier for the visit.

(3) Hospital follow-up care or a hospital visit by the practitioner responsible for the surgery shall be considered part of the surgical follow-up days listed for the procedure and shall not be paid as an independent procedure.

History: 1998-2000 AACS; 2001 AACS; 2005 AACS; 2007 AACS; 2014 AACS; 2018 AACS.

R 418.10405 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10406 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10407 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10410 Incidental surgeries.

Rule 410. The carrier shall not pay a bill for an incidental surgery which is not part of the primary procedure performed, and for which there is no diagnostic evidence or relationship to the covered work injury.

History: 1998-2000 AACS.

R 418.10411 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10415 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10416 Assistant surgeon.

Rule 416. (1) The carrier shall reimburse for an assistant surgeon service for those surgical procedures designated by CMS as allowing additional reimbursement for a surgical assistant. The surgical procedures allowing reimbursement for an assistant surgeon shall be provided separate from these rules on the agency website, www.michigan.gov/wca.

(2) Any of the following may bill assistant surgeon services using modifier -80:

(a) A doctor of dental surgery.

(b) A doctor of osteopathy.

(c) A doctor of medicine.

(d) A doctor of podiatry.

(3) A physician's assistant or an advanced practice nurse with a specialty licensure certification issued by the state may bill assistant surgeon services using modifier -81.

History: 1998-2000 AACS; 2007 AACS; 2018 AACS.

R 418.10417 Ophthalmological surgical procedures.

Rule 417. Ophthalmological surgical procedure codes for the removal of a foreign body include topical anesthesia, fluorescein staining, and lavage.

History: 1998-2000 AACS.

PART 5. RADIOLOGY, RADIATION THERAPY, AND NUCLEAR MEDICINE

R 418.10501 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10502 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10503 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10504 Multiple procedure policy for radiology procedures.

Rule 504. (1) A multiple procedure payment reduction shall apply to specified radiology procedures when performed in a freestanding radiology office, a non-hospital facility, or a physician's office or clinic. The primary procedure, identified by the code with the highest relative value, shall be paid at 100% of the maximum allowable payment. If the provider's charge is less than the maximum allowable payment, then the service shall be paid at 100% of the provider's charge.

(2) The multiple procedure payment reduction shall apply when multiple radiological diagnostic imaging procedures are furnished to the same patient, on the same day, in the same session, by the same physician or group practice that has the same national provider identifier. The agency shall publish in a manual separate from these rules a table listing the diagnostic imaging CPT codes subject to the multiple procedure payment reduction. When more than 1 procedure from the table is furnished to the same patient, on the same day, in the same session, by the same physician or group practice, the procedure with the highest relative value is paid at 100% of the maximum allowable payment. Each additional procedure shall have modifier -51 appended and the technical component shall be reduced to 50% of the maximum allowable payment, or the provider's charge, whichever is less, and the professional component shall be reduced to 75% of the maximum allowable payment, or the provider’s charge, whichever is less.

History: 2007 AACS; 2008 AACS; 2014 AACS.

R 418.10505 Multiple procedure policy for specific nuclear medicine procedures.

Rule 505. (1) The multiple procedure reduction and the use of modifier -51 shall apply to the complete procedure, the technical component, and the professional component, when multiples of the following nuclear medicine diagnostic procedure codes are performed: 78306, 78320, 78802, 78803, 78806, and 78807.

(2) When the procedures listed in subrule (1) of this rule are performed in a hospital setting, the hospital is reimbursed by the cost-to-charge methodology and the multiple payment rule shall apply to the professional component billed by the radiologist.

(3) When the services are performed in an office, clinic, or freestanding radiology office, the reduction shall be applied to the complete procedure.

History: 2007 AACS; 2017 AACS.

PART 7. DENTAL

R 418.10701 Scope.

Rule 701. (1) Dental services, related to, or resulting from, a covered work-related injury are covered under these rules. Incidental dental services are not covered.

(2) A dental provider shall bill services on a standard American dental claim form. The workers' compensation agency shall provide a copy of the claim form and instructions for completion separate from these rules in the health care services manual on the agency's website at www.michigan.gov/wca.

(3) Dental services shall be reimbursed at either the dentist's usual and customary fee or reasonable fee, whichever is less.

History: 2000 AACS; 2005 AACS; 2014 AACS.

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.

History: 2000 AACS; 2002 AACS; 2004 AACS; 2005 AACS; 2008 AACS; 2014 AACS; 2017 AACS; 2019 AACS; 2021 AACS.

R 418.10902 Billing for injectable medications, other than vaccines and toxoids, in office setting.

Rule 902. (1) The provider shall not bill the carrier for administration of therapeutic injections when billing an evaluation and management procedure code. If an evaluation and management procedure code is not listed, then the appropriate medication administration procedure code may be billed.

(2) The medication being administered shall be billed with either the unlisted drug and supply code from the CPT code set or the specific J-code procedure from the HCPCS Level II codebook, as adopted by reference in R 418.10107.

(3) The provider shall list the NDC number for the medication in the upper shaded portion of box 24 of the CMS 1500.

(4) The carrier shall reimburse the medication at average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span, as adopted by reference in R 418.10107. No dispense fee shall be billed for injectable medications administered in the office setting.

(5) If the provider does not list the national drug code for the medication, the carrier shall reimburse the medication using the least costly NDC number by Red Book or Medi-Span for that medication.

History: 2003 AACS; 2005 AACS; 2007 AACS; 2008 AACS; 2014 AACS; 2019 AACS.

R 418.10902a Billing for vaccines and toxoids in office setting.

Rule 902a. (1) When a provider administers a vaccine or toxoid in the office setting, both the vaccine and toxoid shall be billed as separate services. If a significantly separate evaluation and management service is performed, the appropriate evaluation and management service code shall be reported in addition to the vaccine or toxoid administration code pursuant to CPT codebook guidelines, as adopted by reference in R 418.10107.

(2) The vaccine or toxoid being administered and the administration of the vaccine or toxoid shall be billed using the applicable CPT procedure codes pursuant to CPT codebook guidelines, as adopted by reference in R 418.10107.

(3) The provider shall list the NDC number for the vaccine or toxoid in the upper shaded portion of box 24 of the CMS 1500.

(4) The carrier shall reimburse the vaccine or toxoid at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span, as adopted by reference in R 418.10107. No dispensing fee shall be billed for vaccines or toxoids administered in the office setting.

(5) If the provider does not list the NDC number for the vaccine or toxoid, the carrier shall reimburse the vaccine or toxoid using the least costly NDC number listed by Red Book or Medi-Span for that vaccine or toxoid.

History: 2014 AACS.

R 418.10904 Procedure codes and modifiers.

Rule 904. (1) A healthcare service must be billed with procedure codes adopted from "Current Procedural Terminology (CPT®) 2023 Professional Edition" or "HCPCS 2023 Level II Professional Edition," as referenced in R 418.10107. Procedure codes from the CPT code set are not included in these rules, but are provided on the agency's website at www.michigan.gov/leo/bureaus-agencies/wdca. Refer to "Current Procedural Terminology (CPT®) 2023 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 2023 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 2023 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 codes listed in the most recent publication entitled "Current Procedural Terminology (CPT®)" or "HCPCS Level II", as adopted in R 418.10107, the practitioner shall bill the unlisted procedure code. An unlisted procedure code must 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 must be included with the charges submitted to the carrier.

(5) Applicable modifiers from table 10904 must 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

(a) AA: When anesthesia services are performed personally by the anesthesiologist.

(b) 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.

(c) AH: When a licensed psychologist bills a diagnostic service or a therapeutic service, or both.

(d) AJ: When a certified social worker bills a therapeutic service.

(e) AL: When a limited license psychologist bills a diagnostic service or a therapeutic service.

(f) CO: When occupational therapy services are furnished in whole or in part by an occupational therapy assistant.

(g) CQ: When physical therapy services are furnished in whole or in part by a physical therapy assistant.

(h) CS: When a limited licensed counselor bills for a therapeutic service.

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

(j) LC: When a licensed professional counselor performs a therapeutic service.

(k) MF: When a licensed marriage and family therapist performs a therapeutic service.

(l) ML: When a limited licensed marriage and family therapist performs a service.

(m) TC: When billing for the technical component of a radiology service.

(n) 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.

(o) QX: When a certified registered nurse anesthetist or certified anesthesiologist assistant performs a service under the medical direction of an anesthesiologist.

(p) QZ: When a certified registered nurse anesthetist performs anesthesia services without medical direction.

History: 1998-2000 AACS; 2002 AACS; 2003 AACS; 2005 AACS; 2014 AACS; 2015 AACS; 2017 AACS; 2018 AACS; 2019 AACS; 2021 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.10905 Billing for physical and occupational therapy.

Rule 905. (1) A physical or occupational therapist shall bill procedure codes 97010-97799. A licensed occupational therapist or licensed physical therapist in independent practice shall place his or her signature and license or certification number on the bill.

(2) Only a physician, licensed occupational therapist or a licensed physical therapist shall bill for job site evaluation or treatment. The reimbursement for these procedures shall be contractual between the carrier and provider and shall be billed as listed in the following table: Code Descriptor WC500 Job site evaluation; patient specific, initial 60 minutes WC505 each additional 30 minutes, by contractual agreement WC550 Job site treatment; patient specific, initial 60 minutes WC555 each additional 30 minutes, by contractual agreement WC600 Mileage for job site evaluation or job site treatment per mile.

(3) Procedures 97760 and 97761 shall only be reimbursed when billed by a licensed occupational or licensed physical therapist.

(4) Only a licensed physical or occupational therapist shall bill for work hardening services, "by report" or "BR," procedure codes 97545 and 97546.

History: 2000 AACS; 2009 AACS; 2010 AACS; 2018 AACS.

R 418.10907 Rescinded.

History: 2000 AACS; 2005 AACS; 2017 AACS.

R 418.10909 Billing for home health services.

Rule 909. (1) Services provided by a home health agency are considered ancillary services requiring a written prescription by a licensed practitioner certifying medical necessity. A copy of the prescription shall be attached to the bill.

(2) A home health agency shall submit charges to the workers' compensation carrier using the UB-04 claim form.

(3) A home health agency shall use procedure codes from the HCPCS Level II codebook, as adopted by reference in R 418.10107 to identify services provided.

(4) A home health agency shall not bill for the services of a social worker unless the certified social worker is providing medically necessary therapeutic counseling.

(5) A home health agency may bill supplies with 99070, the unlisted CPT® code for miscellaneous supplies, or the appropriate supply code from the HCPCS Level II codebook as adopted by reference in R 418.10107.

(6) When a procedure code is described by the HCPCS Level II codebook as per diem, the "by report" service is reimbursed per visit. When the HCPCS Level II codebook describes a service as time-based the service is "by report," and the procedure is reimbursed according to the time provided.

History: 2002 AACS; 2008 AACS; 2017 AACS; 2018 AACS.

R 418.10911 Billing requirements for ancillary services.

Rule 911. (1) A bill for the following ancillary services shall include a copy of a written prescription by a licensed practitioner. Documentation of a prescription drug or medical supply in the clinical record shall constitute the prescription for services dispensed in a practitioner's office or in a health care organization.

(a) Prescription medications.

(b) Medical supplies and equipment, except when dispensed by a facility or health care organization.

(c) Hearing aids, shoes, and wigs.

(d) Home health services.

(e) Orthoses and prostheses.

(f) Physical and occupational therapy.

History: 2000 AACS.

R 418.10912 Billing for prescription medications.

Rule 912. (1) Prescription drugs may be dispensed to an injured worker by either an outpatient pharmacy or a healthcare organization. These rules apply to the pharmacy dispensing the prescription drugs to an injured worker only after the pharmacy has either written or oral confirmation from the carrier that the prescriptions or supplies are covered by workers' compensation insurance.

(2) When a generic drug exists, the generic drug must be dispensed. When a generic drug does not exist, the brand name drug may be dispensed. A physician may only write a prescription for "DAW," or dispense as written, when the generic drug has been utilized and found to be ineffective or has caused adverse effects for the injured worker. A copy of the medical record documenting the medical necessity for the brand name drug must be submitted to the carrier.

(3) A bill or receipt for a prescription drug from an outpatient pharmacy, practitioner, or healthcare organization must be submitted to the carrier and include the name, address, and Social Security number of the injured worker. An outpatient pharmacy shall bill the service using the National Council for Prescription Drug Program (NCPDP) Workers' Compensation/Property & Casualty Universal Claim Form or an invoice and include either the pharmacy's NPI or NCPDP number, and the NDC of the prescription drug.

(4) A healthcare organization or physician office dispensing the prescription drug shall bill the service on the CMS 1500 claim form. Procedure code 99070 must be used to code the service and the national drug code must be used to describe the drug.

(5) If an injured worker has paid for a prescription drug for a covered work illness, then the worker may send a receipt showing payment, along with the drug information, to the carrier for reimbursement.

(6) An outpatient pharmacy or healthcare organization shall include all of the following information when submitting a bill for a prescription drug to the carrier:

(a) The brand or chemical name of the drug dispensed.

(b) The NDC number from Red Book or Medi-Span, as adopted by reference in R 418.10107.

(c) The dosage, strength, and quantity dispensed.

(d) The date the drug was dispensed.

(e) The physician prescribing the drug.

(7) A practitioner or a healthcare organization, other than an inpatient hospital, shall bill a dispense fee for each prescription drug. A provider shall only be reimbursed for 1 dispense fee for each prescription drug in a 10-day period. A dispense fee must not be billed with "OTC"s, over-the-counter drugs.

History: 2000 AACS; 2002 AACS; 2005 AACS; 2008 AACS; 2014 AACS; 2018 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.10913 Billing for durable medical equipment and supplies.

Rule 913. (1) DME and supplies must be billed using the appropriate descriptor from the HCPCS Level II codebook, as referenced in R 418.10107, for the service. If the equipment or supply is billed using an unlisted or not otherwise specified code and the charge exceeds $35.00, then the acquisition cost must be included with the bill.

(2) Initial claims for rental or purchased DME must be filed with a prescription for medical necessity, including the expected time span the equipment is required.

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

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

(5) If death occurs, rental fees for equipment terminates at the end of the month and additional rental payments must not be made.

(6) 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.

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

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

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

History: 2000 AACS; 2006 AACS; 2008 AACS; 2019 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.10915 Billing for anesthesia services.

Rule 915. (1) Anesthesia services shall consist of 2 components. The 2 components are base units and time units. Each anesthesia procedure code is assigned a value for reporting the base units. The base units for an anesthesia procedure shall be as specified in the publication entitled "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107. The anesthesia codes, base units, and instructions for billing the anesthesia service shall be provided separate from these rules on the agency's website, www.michigan.gov/wca.

(2) When billing for both the anesthesiologist and a certified registered nurse anesthetist or a certified anesthesiologist assistant, the anesthesia procedure code shall be listed on 2 lines of the CMS 1500 with the appropriate modifier on each line.

(3) One of the following modifiers shall be added to the anesthesia procedure code to determine the appropriate payment for the time units:

(a) Modifier -AA indicates the anesthesia service is administered by the anesthesiologist.

(b) Modifier -QK indicates the anesthesiologist has provided medical direction for not more than 4 qualified individuals being a certified registered nurse anesthetist (CRNA), certified anesthesiologist assistant (AA), or resident. The CRNA, AA, or resident may be employed by a hospital, the anesthesiologist, or may be self-employed.

(c) Modifier –AD indicates an anesthesiologist has provided medical supervision for more than 4 qualified individuals being either a certified registered nurse anesthetist, certified anesthesiologist assistant, or anesthesiology resident.

(d) Modifier -QX indicates the certified registered nurse anesthetist or certified anesthesiologist assistant has administered the procedure under the medical direction of the anesthesiologist.

(e) Modifier -QZ indicates the certified registered nurse anesthetist has administered the complete anesthesia service without medical direction of an anesthesiologist.

(4) Total anesthesia units shall be calculated by adding the anesthesia base units to the anesthesia time units.

(5) Anesthesia services may be administered by any of the following:

(a) A licensed doctor of dental surgery.

(b) A licensed doctor of medicine.

(c) A licensed doctor of osteopathy.

(d) A licensed doctor of podiatry.

(e) A certified registered nurse anesthetist.

(f) A licensed anesthesiology resident.

(g) A certified anesthesiologist assistant.

(6) If a surgeon provides the anesthesia service, the surgeon shall only be reimbursed the base units for the anesthesia procedure.

(7) If a provider bills physical status modifiers, then documentation shall be included with the bill to support the additional risk factors. When billed, the physical status modifiers are assigned unit values as defined in the following Anesthesiology Physical Status Modifiers Unit Value table:

P1: A normal healthy patient = 0
P2: A patient who has a mild systemic disease = 0
P3: A patient who has a severe systemic disease = 1
P4: A patient who has a 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

(8) Procedure code 99140 shall be billed as an add-on procedure if an emergency condition, as defined in R 418.10108, complicates anesthesia. Procedure code 99140 shall be assigned 2 anesthesia units. Documentation supporting the emergency shall be attached to the bill.

(9) If a pre-anesthesia evaluation is performed and surgery is not subsequently performed, then the service shall be reported as an evaluation and management service.

History: 2000 AACS; 2003 AACS; 2005 AACS; 2015 AACS; 2017 AACS.

R 418.10916 Rescinded.

History: 1998-2000 AACS; 2002 AACS; 2003 AACS; 2006 AACS.

R 418.10918 Rescinded.

History: 1998-2000 AACS; 2002 AACS.

R 418.10920 Billing for supplementary radiology supplies.

Rule 920. (1) If a description of a diagnostic radiology procedure includes the use of contrast materials, then those materials shall not be billed separately as they are included in the procedure.

(2) A radiopharmaceutical diagnostic low osmolar contrast materials and paramagnetic contrast materials shall only be billed when the CPT codebook instructions indicate supplies shall be listed separately.

(3) If allowed separate reimbursement under this rule, a provider shall include an invoice documenting the wholesale price of the contrast material used and the provider shall be reimbursed the wholesale price of the contrast material.

History: 1998-2000 AACS; 2014 AACS; 2018 AACS.

R 418.10921 Facility billing.

Rule 921. (1) Except for a freestanding surgical outpatient facility, a licensed facility as defined in these rules shall submit facility charges on a UB-04 claim form to the carrier. A copy of the UB-04 form shall be published separate from these rules in a manual provided on the

agency's website at www.michigan.gov/wca. The Official UB-04 Data Specifications Manual referenced in these rules contains instructions for facility billing.

(2) A facility billing for a practitioner service shall bill charges on the CMS 1500 claim form.

History: 1998-2000 AACS; 2005 AACS; 2008 AACS; 2014 AACS.

R 418.10922 Hospital billing instructions.

Rule 922. (1) A hospital shall bill facility charges on the UB-04 national uniform billing claim form and shall include revenue codes, ICD-10-CM and ICD-10-PCS coding, HCPCS codes, and CPT® procedure codes to identify the surgical, radiological, laboratory, medicine, and evaluation and management services. This rule only requires that the following medical records be attached when appropriate:

(a) Emergency room report.

(b) The initial evaluation and progress reports every 30 days whenever physical medicine, speech, and hearing services are billed.

(c) The anesthesia record when billing for a CRNA, certified anesthesiologist assistant, or anesthesiologist.

(2) A properly completed UB-04 shall not require attachment of medical records except for those in subrule (1) of this rule to be considered for payment. Information required for reimbursement is included on the claim form. A carrier may request any additional records under R 418.10118.

(3) If a hospital clinic, other than an industrial or occupational medicine clinic, bills under a hospital's federal employer identification number, then a hospital clinic facility service shall be identified by using revenue code 510 "clinic."

(4) A hospital system-owned office practice shall bill services on the CMS 1500 claim form using the office site of service and shall not bill facility fees.

(5) A hospital or hospital system-owned industrial or occupational clinic providing occupational health services shall bill services on the CMS 1500 claim form using the office site of service and shall not bill facility fees.

History: 1998-2000 AACS; 2003 AACS; 2006 AACS; 2007 AACS; 2008 AACS; 2014 AACS; 2015 AACS; 2017 AACS.

R 418.10923 Hospital billing for practitioner services.

Rule 923. (1) A hospital billing for practitioner services, including a certified registered nurse anesthetist, a certified anesthesiologist assistant, a physician, a nurse who has a specialty certification, and a physician's assistant, shall submit bills on a CMS 1500 form and the hospital shall use the appropriate procedure codes adopted by these rules. A hospital shall bill for professional services provided in the hospital clinic setting as practitioner services on a CMS 1500 form using outpatient hospital for the site of service. A hospital or hospital system-owned office practice shall bill all office services as practitioner services on a CMS 1500 form using office or clinic for the site of service. A hospital or hospital system-owned industrial or occupational clinic providing occupational health services for injured workers shall bill all clinic services as practitioner services on a CMS 1500 using office or clinic for the site of service. A

hospital or hospital system-owned industrial or occupational clinic shall not use emergency department evaluation and management procedure codes. Radiology and laboratory services may be billed as facility services on the UB-04.

(2) A hospital billing for the professional component of a medical service, excluding physical medicine, occupational medicine, or speech and hearing services shall bill the service on a CMS 1500 claim form adding modifier -26 identifying the bill is for the professional component of the service. The bill shall indicate outpatient hospital for the site of service. The carrier shall pay the maximum allowable fee listed in the manual for the professional component of the procedure. If the professional component is not listed, then the carrier shall pay 40% of the maximum allowable fee.

(3) A hospital billing for a radiologist's or pathologist's services shall bill the professional component of the procedure on the CMS 1500 claim form and shall place modifier -26 after the appropriate procedure code to identify the professional component of the service. The carrier shall pay the maximum allowable fee listed in the manual for the professional component of the procedure. If the professional component is not listed, then the carrier shall pay 40% of the maximum allowable fee.

(4) A hospital billing for a certified registered nurse anesthetist or certified anesthesiologist assistant shall bill only time units of an anesthesiology procedure and use modifier -QX with the appropriate anesthesia code, except when billing for a certified registered nurse anesthetist in the absence of medical direction from a supervising anesthesiologist.

History: 1998-2000 AACS; 2002 AACS; 2003 AACS; 2005 AACS; 2008 AACS; 2015 AACS.

R 418.10923b Billing for ambulatory surgery center (ASC) or freestanding surgical outpatient facility (FSOF).

Rule 923b. (1) An ASC or FSOF shall be licensed by the Michigan department of licensing and regulatory affairs under part 208 of the code or if it has an agreement with the centers for Medicare and Medicaid services (CMS) to participate in Medicare. The owner or operator of the facility shall make the facility available to other physicians, dentists, podiatrists, or providers who comprise its professional staff. The following apply:

(a) When a surgery procedure is appropriately performed in the ASC or FSOF and CMS has not assigned a payment code for that procedure, the procedure shall be considered BR.

(b) The ASC or FSOF shall be reimbursed the maximum allowable paid for the payment code, taking into consideration the multiple procedure rule for facilities as defined by CMS.

(2) Billing instructions in this rule do not apply to a hospital-owned freestanding surgical outpatient facility billing with the same tax identification number as the hospital.

(3) An ASC or FSOF shall bill the facility services on the CMS 1500 claim form and shall include modifier SG to identify the service as the facility charge. The place of service shall be "24." The appropriate HCPCS or CPT procedure code describing the service performed shall be listed on separate lines of the bill.

(4) Modifier 50, generally indicating bilateral procedure, is not valid for the ASC or FSOF claim. Procedures performed bilaterally shall be billed on 2 separate lines of the claim form and shall be identified with modifiers, LT for left and RT for right.

(5) An ASC or FSOF shall only bill for outpatient procedures that, in the opinion of the attending physician, can be performed safely without requiring inpatient overnight hospital care

and are exclusive of such surgical and related care as licensed physicians ordinarily elect to perform in their private offices.

(6) The payment for the surgical code includes the supplies for the procedure.

(7) Durable medical equipment, the technical component (-TC) of certain radiology services, certain drugs, and biologicals that are allowed separate payment under the outpatient prospective payment system (OPPS) will be provided separate from the rules on the agency's website, www.michigan.gov/wca.

(8) Items implanted into the body that remain in the body at the time of discharge (such as plates, pins, screws, mesh) from the facility are reimbursable when they are designated by CMS as pass through items. These pass through items will be provided separate from these rules on the agency's website, www.michigan.gov/wca. The facility shall bill implant items with the appropriate HCPCS code that is reimbursable under the OPPS. A report listing a description of the implant and a copy of the facility's cost invoice, including any full or partial credit given for the implant, shall be included with the bill.

(9) Those radiological services that are allowed separate payment under the OPPS will be provided separate from the rules on the agency's website, www.michigan.gov/wca. When radiology procedures are performed intraoperatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and post-operative radiology services may be globally billed.

(10) At no time shall the ASC or FSOF bill for practitioner services on the facility bill.

(11) When an allowed drug or biological, provided separate from these rules on the agency's website, www.michigan.gov/wca, is billed by the ASC or FSOF, it shall be listed by the appropriate HCPCS or CPT procedure code. All of the following apply:

(a) Each allowable drug or biological shall be listed on a separate line.

(b) Units administered shall be listed for each drug or biological.

(c) A dispense fee shall not be billed.

History: 2005 AACS; 2008 AACS; 2010 AACS; 2014 AACS; 2018 AACS.

R 418.10924 rescinded.

History: 1998-2000 AACS; 2003 AACS.

R 418.10925 Billing requirements for other licensed facilities.

Rule 925. (1) A licensed facility, other than a hospital or freestanding surgical outpatient facility, shall bill the facility services on the UB-04 national uniform billing claim form and shall include the revenue codes contained in the Official UB-04 Data Specifications Manual, ICD-10-CM and ICD-10-PCS coding for diagnoses and procedures, and CPT procedure codes for surgical, radiological, laboratory, and medicine and evaluation and management services.

(2) Only the technical component of a radiological service or a laboratory service shall be billed on the standardized UB-04 national uniform billing claim form.

(3) All bills for the professional services shall be billed on a CMS 1500 claim form, using the appropriate CPT procedure code and modifier.

(4) A report describing the services provided and the condition of the patient shall be included with the bill.

History: 1998-2000 AACS; 2003 AACS; 2005 AACS; 2008 AACS; 2014 AACS; 2017 AACS.

R 418.10926 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.

History: 2018 AACS; 2021 AACS.

PART 10. REIMBURSEMENT
SUBPART A. PRACTITIONER REIMBURSEMENT

R 418.101001 General rules for practitioner reimbursement.

Rule 1001. (1) A provider that is authorized to practice in the state of Michigan shall receive the maximum allowable payment in accordance with these rules. A provider shall follow the process specified in these rules for resolving differences with a carrier regarding payment for appropriate health care services rendered to an injured worker. Reimbursement shall be based upon the site of service. The agency shall publish the maximum allowable payment for a procedure performed in the non-facility setting and the maximum allowable payment for a procedure performed in the facility setting.

(2) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.

(3) A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.

(4) A carrier shall pay, adjust, or reject a properly submitted bill within 30 days of receipt. The carrier shall notify the provider on a form entitled "Carrier's Explanation of Benefits" in a format specified by the agency. A copy shall be sent to the injured worker.

(5) A carrier shall not make a payment for any service that is determined inappropriate by the carrier's professional health care review program.

(6) The carrier shall reimburse the provider a 3% late fee if more than 30 calendar days elapse between a carrier's receipt of a properly submitted bill and a carrier's mailing of the payment.

(7) If a procedure code has a maximum fee of "by report," the provider shall be paid its usual and customary charge or the reasonable amount, whichever is less. The carrier shall provide an explanation of its determination that the fee is unreasonable or excessive in accordance with these rules.

History: 1998-2000 AACS; 2005 AACS; 2006 AACS.

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 is used by the agency for determining the maximum allowable payment for medical, surgical, and radiology procedures. The maximum allowable payment is determined by multiplying the appropriate conversion factor by 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/leo/bureaus-agencies/wdca. The relative value units are updated by the agency using codes adopted from "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107. 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.

(2) The conversion factor for medicine, radiology, and surgical procedures is $47.66 for the year 2023 and is effective for dates of service on or after the effective date of these rules.

History: 1998-2000 AACS; 2002 AACS; 2003 AACS; 2004 AACS; 2005 AACS; 2006 AACS; 2014 AACS; 2017 AACS; 2018 AACS; 2019 AACS; 2021 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.101002a Rescinded.

History: 2007 AACS; 2008 AACS; 2009 AACS; 2010 AACS; 2012 AACS; 2014 AACS.

R 418.101002b Rescinded.

History: 2007 AACS; rescinded 2010 AACS.

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.

History: 1998-2000 AACS; 2005 AACS; 2006 AACS; 2008 AACS; 2009 AACS; 2014 AACS; 2018 AACS; 2021 AACS.

R 418.101003a Reimbursement for dispensed medications.

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

The dispense fee for a brand name drug is $3.50.

The dispense fee for a generic drug is $5.50.

(c) Reimbursement for repackaged pharmaceuticals is at a maximum reimbursement of AWP minus 10% based on the original manufacturer's NDC number, as determined by Red Book or Medi-Span, adopted by reference in R 418.10107, plus a dispensing fee of $3.50 for brand name and $5.50 for generic.

(d) All pharmaceutical bills submitted for repackaged products must 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, as adopted by reference in R 418.10107, 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, must be dispensed in 10-day quantities and be reimbursed at the average wholesale price, as determined by Red Book or Medi-Span, adopted by reference in R 418.10107, or $2.50, whichever is greater.

(3) All commercially manufactured topical medications that do not meet the definition of custom compound dispensed by a pharmacy or a provider, must not exceed a 30-day supply. Regardless of dispensing party, reimbursement is a maximum of the acquisition cost, plus a single dispense fee. The single dispense fee is $8.50. A provider shall only be reimbursed 1 dispense fee per topical medication in a 10-day period.

History: 2008 AACS; 2010 AACS; 2012 AACS; 2014 AACS; 2017 AACS; 2018 AACS; 2021 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.101003b Reimbursement for biologicals, durable medical equipment, and supplies.

Rule 1003b. (1) The carrier shall reimburse durable medical equipment (DME), supplies, and biologicals at Medicare plus 5%. The health care services division shall provide the maximum allowable payments for DME, supplies, and biologicals separate from these rules on the agency website, www.michigan.gov/leo/bureaus-agencies/wdca. Biologicals that have NDC numbers must be billed and reimbursed under R 418.10912.

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

(3) If a DME, supply, or biological exceeding $35.00 is not listed in the fee schedule, has no maximum allowable payment (MAP) value in the fee schedule, or is billed with a not otherwise specified code, then reimbursement must be the provider’s acquisition cost, plus a percent mark-up as follows, for purchased DME:

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

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

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

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

(4) If rental DME or supplies are not listed in the fee schedule, have no MAP value in the fee schedule, or are billed with a not otherwise specified code, then reimbursement must be 1 of the following:

(a) The daily rental rate must be calculated using the provider’s acquisition cost, plus 20% divided by 365.

(b) If the provider is the manufacturer of the DME, the daily rental rate must be calculated using the manufacturer’s cost to produce the DME, plus 20% divided by 365.

(5) A provider’s failure to provide the required acquisition cost or manufacturer’s cost may result in denial of reimbursement.

(6) All items and services associated with the DME rental must be included in the daily rental rate as calculated in subrule (4) of this rule and must not be unbundled and billed separately, unless otherwise indicated in the HCPCS Level II codebook as adopted by reference in R 418.10107.

History: 2006 AACS; 2014 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

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® 2023 Professional Edition," and the "HCPCS 2023 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 must 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 must be paid.

(4) If a surgeon uses modifier code -47 when performing a surgical procedure, anesthesia services that were provided by the surgeon and the maximum allowable payment for the anesthesia portion of the service must 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 must 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 must be reimbursed 100% of the maximum allowable payment or billed charge, whichever is less, and the second and remaining surgical procedure or procedures must be identified by modifier code -51 and 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 must 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 must 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 must be reduced by 50% of the maximum allowable payment and payment for the professional component of the procedure must 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 are 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 must 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/leo/bureaus-agencies/wdca.

(8) When modifier -57, initial decision to perform surgery, is added to an evaluation and management procedure code, the modifier -57 must 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 must be multiplied by 25%. Each surgeon is paid 50% of the maximum allowable payment multiplied by 25%, or 62.5% of the MAP. If the maximum allowable payment for the procedure is BR, the reasonable amount must 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 must 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, payment must 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 must 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, the maximum allowable payment for the procedure must 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 must be the same as modifier -80. If the assistant surgeon is a physician's assistant, the maximum level of reimbursement must be the same as modifier -81. If an individual 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 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 must 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 must not be unbundled and reimbursed separately.

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

(15) Modifier -CO must be appended to a procedure code if the procedure was furnished entirely by the occupational therapy assistant, or if the occupational therapy assistant (OTA) has provided a portion of a procedure, separately from the part that is furnished by the occupational therapist, exceeding 10% of the total time for the procedure code. When modifier -CO is used, the procedure code must be reimbursed at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less. Modifier -CO and the corresponding 15% reduction must not be applicable if the occupational therapist has provided more than half of the timed procedure code without the minutes provided by the OTA.

(16) Modifier -CQ must be appended to a procedure if the procedure was furnished entirely by the physical therapy assistant, or if the physical therapy assistant (PTA) has provided a portion of a procedure, separately from the part that is furnished by the physical therapist, exceeding 10% of the total time for the procedure code. When modifier -CQ is used, the procedure code must be reimbursed at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less. Modifier -CQ and the corresponding 15% reduction must not be applicable if the physical therapist has provided more than half of the timed procedure code without the minutes provided by the PTA.

History: 1998-2000 AACS; 2005 AACS; 2007 AACS; 2014 AACS; 2017 AACS; 2019 AACS; 2021 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.101005 Reimbursement for home health services.

Rule 1005. (1) Home health services are reimbursed "by report," requiring submission of a report with the charges on the UB-04 claim form. The carrier shall reimburse the home health agency according to each "by report" procedure listed on the UB-04, billed with the appropriate HCPCS code in accord with R 418.10909.

(2) Home health services shall be reimbursed by the carrier at either the provider's usual and customary charge as defined by these rules or reasonable amount, whichever is less.

(3) Services listed in the HCPCS Level II codebook, as adopted by reference in R 418.10107, as per diem shall be reimbursed per diem or per visit in accord with the description of the code. The per diem visit shall be either at the provider's usual and customary charge or reasonable amount, whichever is less.

(4) Supplies and durable medical equipment (DME) shall be reimbursed pursuant to these rules.

History: 2002 AACS; 2007 AACS; 2008 AACS; 2017 AACS.

R 418.101006 Reimbursement for mental health services.

Rule 1006. (1) A carrier shall only reimburse procedure code 90792 and add on procedure codes 90833, 90836, and 90838 when billed by a psychiatrist who is either a medical doctor (M.D.) or a doctor of osteopathy (D.O.).

(2) A licensed psychologist or a limited license psychologist billing for a diagnostic procedure shall be paid the maximum allowable payment or the practitioner's usual and customary fee, whichever is less.

(3) A licensed psychologist billing for a therapeutic service shall use modifier -AH and shall be paid the maximum allowable payment or the practitioner's usual and customary charge, whichever is less.

(4) For the following providers, therapeutic mental health services shall be reimbursed at 85% of the maximum allowable payment, or the practitioner's usual and customary charge, whichever is less. If a procedure code has a maximum allowable payment of "by report," the maximum allowable payment shall be 85% of the reasonable payment, or the practitioner's usual and customary charge, whichever is less:

(a) -AL limited license psychologist.

(b) -AJ certified social worker.

(c) -LC licensed professional counselor.

(d) -MF licensed marriage and family therapist.

(5) For the following providers, mental health services shall be reimbursed at 64% of the maximum allowable payment, or the practitioner's usual and customary charge, whichever is less. If a procedure code has a maximum allowable payment of "by report," then the maximum allowable payment shall be 64% of the reasonable payment, or the practitioner's usual and customary charge, whichever is less:

(a) -CS limited licensed counselor.

(b) -ML limited licensed marriage and family therapist.

History: 1998-2000 AACS; 2009 AACS; 2014 AACS.

R 418.101007 Reimbursement for anesthesia services.

Rule 1007. (1) The carrier shall determine the maximum allowable payment for anesthesia services by adding the base units to the time units. The carrier shall reimburse anesthesia services at either the maximum allowable payment, or the practitioner's usual and customary charge, whichever is less. Each anesthesia base unit shall be multiplied by $42.00 to determine payment for the base procedure.

(2) Anesthesia base units shall only be paid to an anesthesiologist, a surgeon who provides the anesthesia and performs the surgery, or a certified registered nurse anesthetist providing anesthesia without medical direction of the anesthesiologist. Only 1 practitioner shall be reimbursed for base units, documented by the anesthesia record.

(3) The carrier shall reimburse the time units by the total minutes listed in the "days" or "units" column and the alpha modifier added to the procedure code. Time units are reimbursed in the following manner:

(a) Increments of 15 minutes or portions thereof, for administration of the anesthesia.

(b) Increments of 30 minutes or portions thereof, for supervision or direction of a CRNA or certified anesthesiologist assistant.

(c) In no instance shall less than 1 time unit be reimbursed.

(4) The maximum allowable payment for anesthesia time shall be calculated in the following manner:

(a) If the anesthesiologist administers the anesthesia, then the modifier shall be -AA and the maximum payment shall be $2.80 per minute.

(b) If the anesthesiologist provides medical supervision for more than 4 concurrent anesthesia procedures, then the modifier shall be AD and the maximum payment shall be 3 base units. One time unit shall also be paid if the anesthesiologist is present for induction of anesthesia services at $1.40 per minute.

(c) If the anesthesiologist provides medical direction to a CRNA or certified anesthesiologist assistant, then the modifier shall be QK and the maximum payment shall be $1.40 per minute.

(d) If a CRNA or a certified anesthesiologist assistant administers the anesthesia under the medical direction of an anesthesiologist, then the modifier shall be -QX and the maximum payment shall be $2.80 per minute.

(e) If a CRNA administers anesthesia without medical direction of the anesthesiologist, then the modifier shall be -QZ and the maximum payment shall be $2.80 per minute.

History: 1998-2000 AACS; 2014 AACS; 2015 AACS; 2017 AACS.

R 418.101008 Reimbursement for opioid treatment for chronic, non-cancer pain.

Rule 1008. (1) For purposes of these rules, chronic pain is pain unrelated to cancer or is incident to surgery and that persists beyond the period of expected healing after an acute injury episode. It is pain that persists beyond 90 days following the onset of the pain. The payer shall reimburse for opioids used in the treatment of chronic pain resulting from work-related conditions.

(2) This rule is applicable to opioid treatment of chronic pain for the following:

(a) Injury dates on or after June 26, 2015.

(b) Beginning December 26, 2015, all other injury dates.

History: 2014 AACS; 2015 AACS.

R 418.101008a Required documentation for reimbursement of treatment for chronic, non-cancer pain with opioids.

Rule 1008a. (1) In order to receive reimbursement for opioid treatment beyond 90 days, the physician seeking reimbursement shall submit a written report to the payer not later than 90 days after the initial opioid prescription fill for chronic pain and every 90 days thereafter. The written report shall include all of the following:

(a) A review and analysis of the relevant prior medical history, including any consultations that have been obtained, and a review of data received from an automated prescription drug monitoring program in the treating jurisdiction, such as the Michigan Automated Prescription System (MAPS), for identification of past history of narcotic use and any concurrent prescriptions.

(b) A summary of conservative care rendered to the worker that focused on increased function and return to work.

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

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

(e) A treatment plan that includes all of the following:

(i) Overall treatment goals and functional progress.

(ii) Periodic urine drug screens.

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

(iv) Consideration of weaning the injured worker from opioid use.

(f) An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement shall be reviewed, updated, and renewed every 6 months. The opioid treatment agreement shall outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, and the responsibilities of the prescribing physician and the worker.

(2) The provider may bill the additional services required for compliance with these rules utilizing CPT procedure code 99215 for the initial 90-day report and all subsequent follow-up reports at 90-day intervals.

(3) Providers may bill $25.00 utilizing code MPS01 for accessing MAPS or other automated prescription drug monitoring program in the treating jurisdiction.

(4) A provider performing drug testing, drug screening, and drug confirmation testing shall use the appropriate procedure codes G0480-G0483, G0659, or 80305-80307 listed in the HCPCS or CPT codebook, as adopted by reference in R418.10107.

History: 2014 AACS; 2017 AACS; 2018 AACS.

R 418.101008b Denial of reimbursement for prescribing and dispensing opioid medications used to treat chronic, non-cancer pain.

Rule 1008b. Reimbursement for prescribing and dispensing opioid medications may be denied, pursuant to the act. Denial of reimbursement may occur if the physician reporting and treatment plan requirements as stated in R 418.101008a are not met. Denial of reimbursement shall occur only after a reasonable period of time is provided for the weaning of the injured worker from the opioid medications, and alternative means of pain management have been offered.

History: 2014 AACS.

R 418.101009 Reimbursement for custom compounded topical medication.

Rule 1009. (1) Six months after the effective date of this rule, a custom compound topical medication, as defined in R418.10108, must 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 United States Food and Drug Administration (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.

(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 must be billed using the specific amount of each component drug and its original manufacturers' NDC number included in the compound. Reimbursement must be based on a maximum reimbursement of the AWP minus 10% based on the original manufacturer's NDC number, as published by Red Book or Medi-Span, adopted by reference in R 418.10107, and pro-rated for each component amount used. Components without NDC numbers must not be reimbursed. A single dispensing fee for a compound prescription is $12.50 for a non-sterile compound. The provider shall dispense a 30-day supply per prescription.

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

History: 2014 AACS; 2023 MR 20, Eff. Oct. 12, 2023.

R 418.101010 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.

History: 2014 AACS; 2018 AACS; 2021 AACS.

R 418.101015 General rules for facility reimbursement.

Rule 1015. (1) A facility licensed by this state shall receive the maximum allowable payment in accordance with these rules. The facility shall follow the process specified in these rules for resolving differences with a carrier regarding payment for the appropriate health care services rendered to an injured worker.

(2) The carrier or its designated agent shall assure that the UB-04 national uniform billing claim form is completed correctly before payment. A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.

(3) A carrier shall pay, adjust, or reject a properly submitted bill within 30 days of receipt, sending notice on a form entitled "Carrier's Explanation of Benefits" in a format specified by the agency. The carrier shall reimburse the facility a 3% late fee if more than 30 days elapse between a carrier's receipt of a properly submitted bill and a carrier's mailing of the payment.

(4) Submission of a correctly completed UB-04 claim form shall be considered to be a properly submitted bill. The following medical records shall also be attached to the facility charges as applicable:

(a) Emergency room report.

(b) The initial evaluations and progress reports every 30 days whenever physical medicine, speech, and hearing services are billed by a facility.

(c) The anesthesia record whenever the facility bills for the services of a CRNA, certified anesthesiologist assistant, or anesthesiologist.

(5) Additional records not listed in subrule (4) of this rule may be requested by the carrier and shall be reimbursed in accordance with R 418.10118.

History: 2000 AACS; 2005 AACS; 2008 AACS; 2015 AACS.

R 418.101016 Reimbursement; payment ratio methodology.

Rule 1016. (1) A hospital licensed in Michigan billing facility services shall be reimbursed using the maximum payment ratio methodology for the following services:

(a) Inpatient or observation care.

(b) Emergency department services.

(c) Occupational, physical, and speech therapy services.

(d) Outpatient surgeries.

(e) Laboratory services and outpatient services. If a carrier pays a properly submitted bill or unadjusted portion of the bill within 30 days of receipt, then the payment is calculated by multiplying the charges times the hospital's maximum payment ratio times a multiplier of 107%. If a carrier pays the bill after 30 days, then the multiplier shall be 110% allowing for a 3% late fee.

(2) When a hospital outside the state of Michigan submits a bill for facility services, the carrier may initially process payment by using the method described in subrule (1) of this rule, applying the average maximum payment ratio, as published in the health care services manual. If the facility located outside of Michigan does not accept reimbursement according to Michigan health care services rules, then the carrier shall negotiate the charges with the out-of-state facility or reimburse the facility according to the laws of the state where the facility is located.

(3) If applying the ratio methodology results in an amount greater than the hospital's charge, the carrier shall reimburse the hospital's charge. The only time a carrier shall pay in excess of the charge is if a properly submitted bill was not paid within 30 days and, in that instance, the carrier shall reimburse the charge plus a 3% late fee.

(4) Observation care shall not be for more than 24 hours. If the patient does not meet admission criteria according to the length of stay guidelines, then the patient shall be discharged from observation care.

History: 1998-2000 AACS; 2005 AACS; 2007 AACS; 2009 AACS.

R 418.101017 Rescinded.

History: 1998-2000 AACS; 2004 AACS; 2005 AACS; 2007 AACS.

R 418.101018 Rescinded.

History: 1998-2000 AACS; 2007 AACS.

R 418.101019 Rescinded.

History: 1998-2000 AACS; 2007 AACS.

R 418.101022 Facility reimbursement excluding hospital or freestanding surgical outpatient facility.

Rule 1022. (1) When the following licensed facilities provide services to an injured worker and bill the carrier, the billed services shall be considered by report:

(a) Nursing home.

(b) County medical care facility.

(c) Hospice.

(d) Hospital long-term care unit.

(e) Intermediate care facility or skilled nursing facility.

(2) A licensed facility in subrule (1) of this rule shall be reimbursed by its usual and customary charge or reasonable amount for the service provided, whichever is less. If a carrier does not reimburse the facility within 30 days of receipt of a properly submitted bill, the carrier shall reimburse the facility an additional 3% late fee.

History: 1998-2000 AACS; 2005 AACS.

R 418.101023 Reimbursement for ASC or FSOF.

Rule 1023. (1) Reimbursement for surgical procedures performed in an ASC or FSOF shall be determined by using the ASC rate published by CMS. The formula for determining the maximum allowable paid (MAP) for a surgical procedure in an ASC or FSOF is determined by multiplying the (Medicare ASC rate) X (1.30). The MAP shall be published in the health care services fee schedule.

(2) When 2 or more surgical procedures are performed in the same operative session, the facility shall be reimbursed at 100% of the maximum allowable payment or the facility's usual and customary charge, whichever is less, for the procedure classified with the highest payment rate. Any other surgical procedures performed during the same session shall be reimbursed at 50% of the maximum allowable payment or 50% of the facility's usual and customary charge,

whichever is less, unless the procedure is not subject to the multiple procedure discount as indicated by CMS in the health care services ASC fee schedule. A facility shall not unbundle surgical procedure codes when billing the services.

(3) When an eligible procedure is performed bilaterally, each procedure shall be listed on a separate line of the claim form and shall be identified with LT for left and RT for right. At no time shall modifier 50 be used by the facility to describe bilateral procedures.

(4) Implants are included in the maximum allowable paid unless the CMS list it as a pass through item. Pass through items will be provided on the agency's website, www.michigan.gov/wca. If an item is implanted during the surgical procedure and the ASC or FSOF bills the implant and includes the copy of the invoice, then the implant shall be reimbursed at the cost of the implant plus a percent markup as follows:

(a) Cost of implant: $1.00 to $500.00 shall receive cost plus 50%.

(b) Cost of implant: $500.01 to $1000.00 shall receive cost plus 30%.

(c) Cost of implant: $1000.01 and higher shall receive cost plus 25%.

(5) Laboratory services shall be reimbursed by the maximum allowable payment as determined in R 418.101503.

(6) When a radiology procedure is performed intra-operatively, only the technical component shall be billed by the facility and reimbursed by the carrier when allowed separate payment by CMS. The MAP for the technical component shall be published in the health care services ASC fee schedule. The professional component shall be included with the surgical procedure. Pre-operative and post-operative radiology services may be globally billed.

(7) When the freestanding surgical facility provides durable medical equipment, the items shall be reimbursed in accord with R 418.101003b.

History: 2005 AACS; 2006 AACS; 2008 AACS; 2010 AACS; 2014 AACS; 2017 AACS.

PART 11. HOSPITAL PAYMENT RATIO

R 418.101101 Calculation and revision of payment ratio for Michigan hospitals.

Rule 1101. (1) The workers' compensation agency shall annually calculate and revise, under the provisions of *1969 PA 306, MCL 24.201 et seq*. the payment ratios for all Michigan hospitals. The calculation shall be made using a hospital's most recent fiscal year information that is submitted to the Michigan department of health and human services, hospital and clinic reimbursement division, preceding each annual calculation. The information used shall be that reported to the Michigan department of health and human services on the hospital's statement of patient revenues and operating expenses, G2 worksheet. The workers' compensation agency shall complete the payment ratio calculation when the figures are available from the Michigan department of health and human services and shall annually provide the hospital ratio calculations on the agency's website, www.michigan.gov/wca.

(2) The workers' compensation agency shall calculate a hospital's cost-to-charge ratio by dividing each hospital's total operating expenses by total patient revenues as reported on the hospital's statement of patient revenues and operating expenses, G2 worksheet.

History: 1998-2000 AACS; 2004 AACS; 2005 AACS; 2017 AACS.

R 418.101102 Calculation and revision of payment ratio for hospitals outside Michigan.

Rule 1102. The workers' compensation agency shall annually calculate and revise, under the provisions of 1969 PA 306, as amended, being §24.201 et seq. of the MCL, at the same time as calculating Michigan hospitals' payment ratios, a weighted state average payment ratio to be used for hospitals that are located outside the state of Michigan. The payment ratio shall be calculated by dividing the total hospital operating expenses for Michigan by the total hospital patient revenues for Michigan as reported under R 418.1101(1).

History: 1998-2000 AACS; 2005 AACS.

R 418.101103 Adjustments to hospital's payment ratio.

Rule 1103. (1) A hospital may apply to the agency for an adjustment of the hospital's maximum payment ratio.

(2) The hospital shall apply for an adjustment on a form and in a manner prescribed by the workers' compensation agency.

(3) If the agency determines that a hospital's ratio of total operating expenses to total patient revenues, as reported on the hospital's statement of patient revenues and operating expenses, G2 worksheet, for a hospital's most recent fiscal year is higher than the payment ratio calculated according to R 418.1101, so that the amount of underpayment is more than $100,000.00 or is equal to or greater than 2/10 of 1% of the hospital's operating expenses for the year, then the agency shall revise the payment ratio and shall notify the hospital and all carriers of the revised payment ratio within 45 days after the receipt of a properly submitted request for an adjustment.

(4) If a hospital's request for an adjustment to the hospital's payment ratio is denied by the workers' compensation agency, then a hospital may request reconsideration and appeal of the agency's action regarding the hospital's request for adjustment of its payment ratio.

History: 1998-2000 AACS; 2005 AACS.

R 418.101104 Request for adjustment to hospital's maximum payment ratio; agency's response.

Rule 1104. (1) Within 60 days of the agency's receipt of a hospital's request for adjustment to the hospital's maximum payment ratio, the workers' compensation agency shall notify the hospital of the action on the adjustment request and shall notify the hospital of the hospital's right to provide additional information to request reconsideration of the agency's action.

(2) The workers' compensation agency shall also furnish the hospital with an appeal form. The appeal form shall include an explanation of the appeal process.

History: 1998-2000 AACS; 2005 AACS.

R 418.101105 Agency's action on request for adjustment of maximum payment ratio; hospital's appeal.

Rule 1105. (1) If a hospital is in disagreement with the action taken by the workers' compensation agency on its request for adjustment of the hospital's maximum payment ratio, then a hospital may, within 30 days of receipt of the agency's action on the hospital's request for adjustment to its maximum payment ratio, deliver or mail an appeal of the agency's action to the agency. The appeal shall include a detailed statement of the reasons for disagreement and shall request reconsideration of the agency's action on the hospital's request for adjustment.

(2) The workers' compensation agency shall hold a hearing within 30 days of the receipt of a hospital's appeal under section 847 of the act.

History: 1998-2000 AACS; 2005 AACS.

PART 12. CARRIER'S PROFESSIONAL HEALTH CARE REVIEW PROGRAM

R 418.101201 Carrier's health care review program.

Rule 1201. (1) The carrier shall have both a technical health care review program and a professional health care review program.

(2) Health care review shall be conducted in a reasonable manner on bills submitted by a provider for health care services furnished because of a covered injury or illness arising out of and in the course of employment.

History: 1998-2000 AACS.

R 418.101203 Carrier's technical health care review program.

Rule 1203. Under the technical health care review program, the carrier shall do all of the following:

(a) Determine the accuracy of the procedure coding. If the carrier determines, based upon review of the bill and any related material which describes the procedure performed, that the procedure is incorrectly or incompletely coded, then the carrier may re-code the procedure, but shall notify the provider of the reasons for the recoding within 30 days of receipt of the bill under part 13 of these rules.

(b) Determine that the amount billed for a procedure does not exceed the maximum allowable payment established by these rules. If the amount billed for a procedure exceeds the maximum allowable payment, then the carrier shall reimburse the maximum allowable payment for that procedure.

(c) Identify those bills and case records which, under R 418.101205, shall be subject to professional health care review.

History: 1998-2000 AACS.

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.

History: 1998-2000 AACS; 2003 AACS; 2005 AACS; 2021 AACS.

R 418.101205 Scope of professional health care review.

Rule 1205. (1) The carrier, or it's review company, shall review case records and health-service bills, or both, under the professional health care review program as follows:

(a) A case where health care service payments, excluding inpatient hospital care, exceed $20,000.00.

(b) A case involving inpatient hospital care.

(2) The carrier or other entity may at any time review any case record or bill which the carrier or the other entity believes may involve inappropriate, insufficient, or excessive care.

History: 2000 AACS; 2005 AACS.

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.

History: 2000 AACS; 2003 AACS; 2005 AACS; 2010 AACS; 2021 AACS.

R 418.101207 Types of certification.

Rule 1207. (1) Certification shall be either unconditional or conditional.

(2) The workers' compensation agency shall issue unconditional certification for a period of 3 years.

(3) The agency may issue conditional certification if it is determined that the carrier or other entity does not fully satisfy the criteria in R 418.101206(3). If the carrier or other entity agrees to undertake corrective action, then conditional certification shall be granted by the agency for a maximum period of 1 year.

(a) If the workers' compensation agency receives multiple written complaints regarding a carrier, or the carrier's review process, and the agency determines the complaints are valid, or that the carrier has not processed payment for medical services in accord with these rules, then the agency may issue conditional certification.

(4) The workers' compensation agency may at any time modify an unconditional certification to a conditional certification if the agency determines that the carrier or other entity fails to satisfy the criteria set forth in R 418.101206(3).

(5) The carrier shall have the right to appeal the certification decisions under the procedures in these rules.

(6) Failure to file Annual Report (WC406) or Professional Certification for Health Care Review Program (WC590) may result in denial or downgrading of the certification of a Health Care Review Program by the workers' compensation agency.

History: 2000 AACS; 2005 AACS; 2012 AACS.

R 418.101208 Renewal of certification.

Rule 1208. (1) A carrier or other entity shall apply to the workers' compensation agency for renewal of certification in the manner prescribed by the agency, submitting the application within 90 days before the expiration date on the certification.

(2) A carrier or other entity shall receive renewal of certification upon receipt of an updated description of its program as specified in R 418.101206.

History: 2000 AACS; 2005 AACS; 2015 AACS.

R 418.101209 Carrier's request for reconsideration of professional review certification.

Rule 1209. (1) Within 30 days of the agency's denial of a carrier's request for professional review program certification, the agency shall notify the carrier of the reasons for denial of the certification and shall notify the carrier of its right to request reconsideration of the denial providing additional information.

(2) A carrier shall notify the agency, within 30 days of receipt of the professional review program certification denial, of its disagreement with the action of the agency. The carrier's notice to the agency of disagreement with the agency's denial shall include a detailed statement of the reasons for the disagreement and shall request reconsideration.

History: 2000 AACS; 2005 AACS.

R 418.101210 Carrier's request for reconsideration of professional review program certification; response.

Rule 1210. (1) Within 30 days of receipt of a carrier's request for reconsideration of professional review program certification, the workers' compensation agency shall notify the carrier of the actions taken and shall furnish a detailed statement of the reasons for the action taken.

(2) The agency shall furnish the carrier with an appeal form. The appeal form shall include an explanation of the appeal process.

(3) If a carrier is in disagreement with the action taken by the agency on its request for reconsideration, then a carrier shall deliver or mail its appeal to the agency.

(4) The workers' compensation agency shall hold a hearing within 30 days of the receipt of a carrier's appeal of the agency's decision regarding certification of the carrier's professional review program under section 847 of the act.

History: 2000 AACS; 2005 AACS.

PART 13. PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIER AND PROVIDER REGARDING BILL

R 418.101301 Carrier's adjustment or rejection of properly submitted bill.

Rule 1301. (1) If a carrier adjusts or rejects a bill or a portion of the bill, then the carrier shall notify the provider within 30 days of the receipt of the bill of the reasons for adjusting or rejecting the bill or a portion of the bill and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action. The carrier shall set forth the specific reasons for adjusting or rejecting a bill or a portion of the bill and request specific information on a form, "Carrier's Explanation of Benefits," prepared by the agency pursuant to the reimbursement provisions in these rules.

(2) If the provider sends a properly submitted bill to a carrier and the carrier does not respond within 30 days, and if a provider sends a second properly submitted bill and does not receive a response within 60 days from the date the provider supplied the first properly submitted bill, then the provider may file an application with the agency for mediation or hearing. The provider shall send a completed form entitled "Application for Mediation or Hearing" to the agency and shall send a copy of this form to the carrier.

(3) The carrier shall 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 if that amount is disputed by the carrier under its utilization review program or if the amount is more than the maximum allowable payment established by these rules. The carrier shall request the employee to notify the carrier if the provider bills the employee.

History: 2000 AACS; 2005 AACS; 2014 AACS.

R 418.101302 Provider's request for reconsideration of properly submitted bill.

Rule 1302. A provider may request reconsideration of its adjusted or rejected properly submitted bill by a carrier within 60 days of receipt of a notice of an adjusted or rejected bill or a portion of the bill. The provider's request to the carrier for reconsideration of the adjusted or rejected bill shall include a detailed statement of the reasons for disagreement with the carrier's adjustment or rejection of a bill or a portion of the bill.

History: 1998-2000 AACS.

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.

History: 2000 AACS; 2005 AACS; 2012 AACS; 2021 AACS.

R 418.101304 Disputes.

Rule 1304. (1) If a carrier adjusts or rejects a bill or a portion of a bill under these rules, then a notice given under R 418.101301(1) creates an ongoing dispute for the purpose of section 801 of the act. The time for making payment of a bill under section 801 of the act shall not run unless the bill is properly submitted according to applicable rules and statutes.

(2) Any dispute that concerns any of the following shall be resolved as if an application for mediation or hearing was filed under section 847 of the act:

(a) The medical appropriateness of health care or a health care service.

(b) Utilization of health care or a health care service.

(c) The need for health care or a health care service.

(d) Any dispute over the cost of health care or a health care service.

(3) If the dispute results in the denial of medical treatment for a worker, or if there is a petition by an employer to stop the employer's liability for medical benefits previously ordered, including proceedings under subrule (6) of this rule, then the dispute shall receive the same expedited treatment accorded to 60-day cases under section 205 of the act, except that the agency may refer the matter to mediation before a representative of the director.

(4) A dispute under this rule may be submitted to arbitration under section 864 of the act.

(5) A dispute under this rule may be handled as a small claim under section 841(2) to (10) of the act if it meets the requirements of that section.

(6) If a carrier is required by the terms of an award to provide medical benefits, then the carrier shall continue to provide those benefits until there is a different order by any of the following entities:

(a) A magistrate.

(b) The appellate commission.

(c) The court of appeals.

(d) The supreme court. This subrule does not preclude the use of the maximum allowable payments provided by these rules for the payment of bills by carriers. If a carrier files an application to stop or limit its liability under this subrule, the carrier shall receive the expedited treatment provided for under subrule (3) of this rule.

(7) If the director believes that a provider is not in compliance with these rules, then the director may on his or her own motion give notice to the parties and schedule a hearing for the purpose of determining compliance.

History: 2000 AACS; 2005 AACS; 2017 AACS.

R 418.101305 Resolution of disputes.

Rule 1305. (1) If a carrier adjusts a fee or rejects a bill under these rules, then a notice given pursuant to R 418.101301 creates a continuing dispute for the purpose of section 801 of the act. The time for making payment of a bill under section 801 of the act shall not run unless the bill is properly submitted according to applicable rules and statutes.

(2) A magistrate, as provided under sections 315 and 847 of the act and R 408.34 and R 408.35, shall resolve any dispute that concerns any of the following:

(a) The medical appropriateness of health care or a health care service.

(b) Utilization of health care or a health care service.

(c) The need for health care or a health care service.

(d) Any dispute over the cost of health care or a health care service.

(3) The agency may participate in any hearings that concern disputes when there is an issue that affects the provisions of these rules regarding maximum fees, medical appropriateness, or utilization of health care or health care services.

History: 2000 AACS; 2005 AACS.

PART 14. DATA ACQUISITION

R 418.101401 Annual medical payment report.

Rule 1401. (1) Payments for medical services received by injured workers shall be reported to the workers' compensation agency on a form prescribed by the agency entitled "Annual Medical Payment Report (WC-406)." The agency shall provide instruction to the carriers and service companies regarding completion of the form. The annual medical payment report shall cover the periods January 1 through December 31 and shall include all of the following information:

(a) The total number of medical payments for health care services for medical cases, wage loss cases, and the carrier's total number of worker's compensation cases in each category during the reporting period.

(b) Medical only cases, defined as those cases where no indemnity was paid, and the total medical payments made by the carrier for those cases.

(c) Wage loss cases, defined as those cases in which wage loss or indemnity was paid, and the total medical payments made by the carrier for those cases. For the purposes of this annual medical payment report, once wage loss benefits are paid, then the case shall always be reported as wage loss.

(d) For the purpose of the Annual Medical Payment Report (WC-406), “medical services” is defined as all reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws in this state as legal, and furnished by licensed practitioners within the scope of their practice. The report shall not include indemnity payments, travel expenses, payments for independent medical examinations, legal expenses, vocational rehabilitation, or on-site or telephonic case management expenses.

(2) The annual medical payment report (WC-406) shall be due to the agency by February 28 of each year. Form WC-406 is an online report and must be completed via the Health Care Services Online Program provided on the agency’s website, www.michigan.gov/wca.

(3) A carrier, self -insured, or group shall submit required forms either directly or through a third-party vendor, to the agency at such time as the director deems appropriate. The forms required are both of the following:

(a) Certification of a carrier's professional health care review program (form WC590).

(b) Annual medical report (WC406).

History: 1998-2000 AACS; 2005 AACS; 2010 AACS; 2014 AACS.

R 418.101402 Access to workers' compensation case records.

Rule 1402. (1) The workers' compensation agency shall have access to necessary workers' compensation health care records, medical bills, and other information concerning health care or health service from workers' compensation carriers or providers.

(2) The agency may review the records and medical bills of any provider determined by a carrier to not be in compliance with the rules or to be requiring unjustified treatment, hospitalization, or office visits. If a carrier requests the agency to perform an on-site review of specific records and medical bills of a provider, then the agency shall arrange a mutually acceptable visit date with the provider, by telephone or in writing, at least 15 working days before the visit. The agency shall confirm the date of the visit in writing not less than 10 working days in advance. The agency shall, by that time, identify for the provider the records, which the agency wishes to review. The records shall remain at the provider's place of business.

(3) The workers' compensation agency shall ensure confidentiality of the individual case records regarding health care services provided to any individual.

History: 1998-2000 AACS; 2005 AACS.

R 418.101404 Access to carrier data for payment of medical claims.

Rule 1404. (1) The workers' compensation agency shall have access to payment data from the carrier in the form of the carrier's explanation of benefits and medical bills for the purposes of data analysis.

(2) A carrier shall be notified by the agency when information is to be submitted not less than 60 days before the date required.

(3) The agency shall ensure confidentiality of the billing records provided by the selected carriers.

History: 1998-2000 AACS; 2005 AACS.

PART 15 PROCEDURE CODE AND REIMBURSEMENT TABLES

R 418.101501 Tables for health care services and procedures.

Rule 1501. The agency shall provide separate from these rules a manual, tables, and charts containing all of the following on the agency’s website, www.michigan.gov/wca:

(a) Procedure codes and relative value units for the medical, surgical, and radiology services.

(b) Reference to the ancillary services identified in the HCPCS Level II codebook as adopted by reference in R 418.10107.

(c) Maximum payment ratios for hospitals.

(d) A copy of the billing forms and instructions for completion.

History: 1998-2000 AACS; 2001 AACS; 2003 AACS; 2005 AACS; 2014 AACS; 2018 AACS.

R 418.101502 Rescinded.

History: 2003 AACS; 2005 AACS; 2007 AACS.

R 418.101503 Laboratory procedure codes and maximum allowable payments.

Rule 1503. (1) The workers' compensation agency shall determine the maximum allowable payment for the laboratory procedure codes found in the CPT and HCPCS codebooks, as adopted by reference in R418.10107. 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 CPT code set have assigned relative values and shall be provided on the agency's website at www.michigan.gov/wca.

(3) The maximum allowable payments for the laboratory and pathology procedures shall be provided on the agency's website, www.michigan.gov/wca.

(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, as adopted by reference in R418.10107. A maximum of one service unit per procedure code per date of service shall be billed with these codes.

History: 2003 AACS; 2005 AACS; 2014 AACS; 2017 AACS; 2018 AACS.

R 418.101504 Rescinded.

History: 2003 AACS; 2004 AACS; 2006 AACS; 2007 AACS; 2009 AACS.