

Michigan Workers' Disability Compensation and You



1

General Policy -Who's Eligible?

- Basically every public and private employee
- Medical services performed by licensed, registered or certified health care providers, providing services to the extent that licensure, registration or certification law allows.

2

General Policy – Employee Responsibilities

- Must report injury or illness received during course of employment to employer.
- If employee receives a bill for health care services, the employee should submit the bill to the worker's compensation carrier if known, if not, then the employer.
- The worker can treat with a physician of his or her choice by notifying the employer/carrier of their intention after the initial 28 days of medical treatment.

3

General Policy – Employer Responsibilities

- Must furnish or cause to have furnished all necessary and reasonable medical, surgical, and hospital services and medicines, other attendance or treatment recognized as legal.
- An employer has the right to direct the employee to a provider of the employer's choice for the first 28 days and should report the injury to their workers compensation carrier.
- The employer informs the provider of the name and address of their insurer to whom bills should be sent.

4

General Policy – Carrier Responsibilities

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

- 1) Establishes a case record.
- 2) Determines compensability
- 3) Reviews medical bills for payment. Required to pay within 30 days of receipt of a provider's properly submitted bill or must pay a 3% late fee (R418.10117(3)).
- 4) Notifies the provider of their decision to adjust or reject a provider's bill on a form entitled "The Carrier's Explanation of Benefits."

5

Billing Policy

- When a provider treats an injured worker, the claim is sent to the workers' compensation carrier within one year of treatment.
- Providers must submit charges to the carriers on the appropriate health insurance claim forms (CMS-1500) and attach any documentation required by the Health Care Services Rules.
- Documentation required by the rules must be legible.
- A carrier must pay only licensed providers.

6

Billing Policy

- The provider shall be paid the maximum allowable payment (MAP) or their usual and customary fee, whichever is lower.
- However...Rule 418.10101(4) states that if a provider and a carrier have a contract that pays less than the fee schedule, than the contract is exempt from the fee schedule.

7

Billing Policy

- A provider may not bill the employee for any amount of the charge for health care services provided for treatment of a covered injury or illness.
- A provider may not balance bill the amount that is disputed by utilization review, or the amount that exceeds the MAP.

8

Billing Policy

- If provider receives no response in 30 days, the provider should send a second copy of the bill, marked DB, to the carrier and add a 3% late fee.
- If the carrier still does not respond within 30 days of the second bill, file a request for mediation.
- When there are balances due to the utilization review, the provider should send a request for reconsideration to the carrier, and if unresolved within 60 days, file a request for mediation.

9

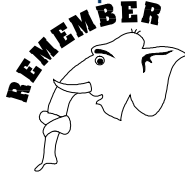
Billing Policy

- Providers are responsible for submitting claim forms to the carrier for payment.
- If an employer refuses to give you carrier information, contact the bureau at (517) 284-8922 with the following information:
 - Employer name and address.
 - Date of injury or date of first symptoms for reported illness.
- This information can also be found at www.michigan.gov/wca.

10

Billing Policy

- The provider's medical record is the basis for determining necessity and for substantiating the service(s) rendered; therefore, the carrier may request the record.
- Medical records must be legible and include the information required in R 418.10113 (3).



11

Billing Policy

- R418.10113(3) states "The provider's medical record of initial visit and the progress report shall include all of the following:
 - 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.

12

Billing Policy

- d) As 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.

13

Billing Policy

Providers are required to submit documentation for the following:

- 1) The Initial visit.
- 2) Evaluation for physical treatment (PT, OT, CMT, OMT)
- 3) A progress report every 30 days for physical treatment.
- 4) A consultation.
- 5) A written report is required whenever the professional component of an x-ray is billed.

14

Billing Policy

Providers are required to submit documentation for the following:

- 5) A functional capacity or work evaluation
- 6) When billing a BR (By Report) service, a description of the service is required.
- 7) Whenever a modifier is used to describe unusual circumstances.
- 8) Whenever the procedure code descriptors includes a written report.

15

Payment Policy

- The carrier is required to reimburse for all medically necessary and reasonable health services **and that are consistent with accepted medical standards.**
- Services must be provided to the extent that licensure, registration or certification allows.
- The amount paid will be the provider's usual and customary fee or the maximum allowable payment, whichever is less.
- Payment is for actual services rendered for the covered work injury or illness only.

16

Payment Policy

- A carrier is responsible to ensure that services billed are medically necessary.
- They are required to perform professional review whenever the charges on the case exceed \$20,000.00, there is an inpatient admission, or on any case deemed appropriate by the carrier.

17

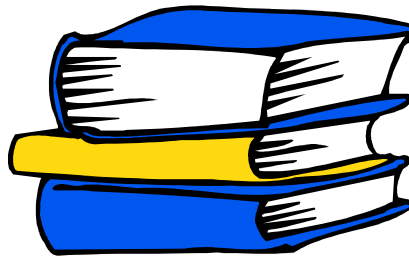
Payment Policy

- Services not substantiated by documentation may be denied. The EOB must reflect reason for denial.
- Services not accurately coded may have the code changed. If provider disputes this, only the difference is in dispute.
- Carrier must not deny payment and must not take the position that the acceptance of payment constitutes agreement with the decision.

18

Payment Policy

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



19

Payment Policy – Payment for “By Report” (BR) Services

- Supplies (A4000-A8999), durable medical equipment (E0100-E9999), and Orthotics (L0000-L9999) are paid at the Medicare rate plus 5%.
- Services without an assigned RVU are reimbursed at a reasonable amount or at your usual and customary fee, whichever is less.
- Reasonable is defined as “a payment based upon the amount generally paid in the state for a particular procedure code using data available from the provider, carrier, or the bureau.”

20

Payment Policy – Total Procedures Billed Separately

- Certain procedures (i.e., x-rays) can be broken into professional and technical portions of the service. Two providers can separately bill a component.
- Providers must indicate on the claim form that the technical and professional components were performed separately by use of a modifier to the CPT code.
- Modifier –26 indicates only the professional component was performed
- Modifier –TC indicates that only the technical component was performed.

21

Payment Policy – Explanation of Benefits (EOB) Form

The carrier shall ensure that the following information is included on the EOB:

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

22

Payment Policy – Disputed Payments

- When a provider receives a reduction or denial of a charge, the provider may submit to the carrier a **written request for reconsideration within 60 days of receipt of payment**.
- Include detailed explanation and documentation to substantiate the charge/service in question.
- The payer must review, re-evaluate, and respond within 30 days of the date of receipt.
- The response must explain the reasons and cite the specific policy and rule upon which the adjustment was made.

23

Payment Policy – Mediation Applications (104B)

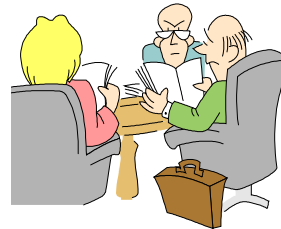
Provider reasons for requesting Mediation Hearings:

- No response to the provider's bill.
- Payment dispute unresolved though the reconsideration process.
- Whenever you learn that the worker's case is contested. If a worker does not dispute the carrier's denial of a case, the worker or their health insurer becomes responsible for the payment.
- Providers request a hearing using form 104B. Patients should call (888) 396-5041 and request a form 104A.

24

Payment Policy – Mediation Applications (104B)

- The requesting party submits the original form to the bureau and sends a copy to the carrier.
- Documentation is not sent to the bureau with the application, but is taken to the mediation site.



25

Evaluation and Management

- E/M codes can be grouped into three categories: Office visit and Hospital visits. See CPT manual for complete instructions for identifying and billing E/M services.
- Use codes 99201-99350 to describe services for an injured worker. (99201-99203, 99212-99214)

26

Physical Medicine and Manipulation

- Initial office visit to determine the need for manipulation is billed with the appropriate E/M code.
- Ongoing CMT include a pre-manipulative patient evaluation.
- E/M with ongoing CMT is only payable when documentation supports a significant change in signs or symptoms, a periodic re-evaluation is required, or the evaluation of another work related injury.
- The E/M would be reported using modifier -25

27

Physical Medicine and Manipulation

- CMT is billed using 98940, 98941, or 98942 as appropriate.
- Procedure code 98943 may be payable.
- Chiropractors may bill for 97001-97799 physical medicine services. 97010 is not reimbursable with an E&M on the same day.
- Physical medicine services will be paid when the therapy provided is likely to restore function and is specific to the improvement in the patient's condition.

28

•Physical Medicine and Manipulation

The following documentation must be submitted to the carrier:

- The initial evaluation including:
 - 1) Evaluation of function in measurable terms based on physical findings and problem identification.
 - 2) A goal statement
 - 3) A treatment plan with measurable goals
 - 4) Description of objective findings
 - 5) Documentation of limitations, if any
- A progress report every 30 days documenting progress toward measurable goals
- A discharge summary

29

•Physical Medicine and Manipulation

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

30

•Physical Medicine and Manipulation

- When a DC performs a periodic re-evaluation then a report shall accompany the bill. The report shall include all of the following:
 - a) A description of 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

31

•Physical Medicine and Manipulation

- Physical treatment services are payable on the same day as the evaluation.
- **Supervised modalities**, those not requiring one-on-one contact by the provider will not be paid unless accompanied by therapeutic procedures.
- **Constant attendance modalities**, those services requiring one-on-one with the provider, may be billed and paid without being accompanied by the therapeutic procedure.

32

Special Reports

- If a carrier requests reports over and above the reports contained within the medical record, then the provider is reimbursed for the reports.
- Bill using code 99199 using modifier 32 for carrier requested service.
- Bill \$25.00 per page for up to 3 pages. Over three pages reimbursement is “BR”

33

Copies of Reports and Records

- Providers are required to include certain copies of medical records and may not charge for those required reports.
- When the carrier requests additional medical records pertaining to a **specific date of injury** or duplicate copies of medical record, you may bill for those.

34

Copies of Reports and Records

The carrier will reimburse the provider as follows:

- 45 cents per page, plus
- The actual cost of mailing the records, plus
- A handling fee of \$2.50 per 15 minute increment

35

Copies of Reports and Records

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

- A carrier or their agent (attorney or review company)
- An injured worker or their agent (attorney)
- The provider may bill their usual and customary charge for records that do not pertain to a specific date of injury (other than the case record).

36