

CHAPTER 8

CODING AND REIMBURSEMENT STANDARDS

A. PAYMENT OVERVIEW

In order to properly process medical bills and assist providers, MCOs shall demonstrate a clear understanding of the provider billing requirements as detailed in BWC's Provider Billing and Reimbursement Manual by incorporating bill processing procedures and practices which enforce those requirements. The MCO shall determine reimbursement eligibility on HPP bills for claims assigned to that MCO. Payment obligations are not based on a claim's filing date, date of injury, or the bill's date of service.

1. Payment for Allowed Condition(s)

The MCO directly reimburses for medical services provided in the treatment of work-related allowed (i.e., compensable) conditions. Workers' compensation reimbursements are founded on the concept of medical necessity, based on provisions of BWC statutes. Regardless of any exclusions or limitations placed on medical services, all services and supplies must be medically necessary and related to the allowed condition. The MCO should only determine reimbursement eligibility on services provided in the treatment of allowed or reasonably related conditions.

Providers should bill the appropriate responsible party for services unrelated to the compensable allowed condition in the claim.

Providers should submit complete fee bills to the appropriate MCOs. If the claim is in the determination process, MCOs will pend the completed bills and submit them to BWC when the claim is in the allowed status.

2. Medical Documentation

MCO shall not regularly require providers to submit medical documentation for previously approved treatment. MCOs shall not deny payment for previously approved treatment if medical documentation is not attached to a provider invoice, unless such documentation is necessary **to price or evaluate** the service (e.g. unclassified/NOC procedures). However, the MCO may request medical documentation in cases where services billed do not correspond to treatment that was requested and approved or if the MCO needs information to determine what services were provided.

Receipt of Medical Bills

- The MCO is required to accept and process all bills received regardless of the means of submission (i.e. fax, hardcopy, electronic).
- The MCO is required to date stamp every invoice (bill) received with the Receipt Date as defined in its contract with BWC.
- For bills with a date of service prior to July 29, 2011, the MCO must consider all bills it receives within 2 years of the service date eligible to consider for payment. In cases where a claim or condition is allowed through an Industrial Commission order, bills are eligible until six months after the mailing date of the final order

allowing the claim or condition. If this date is more than two years after the service date, the MCO must submit the bills priced at \$0.00 to BWC and then request that they be adjusted.

- For bills with a date of service on or after July 29, 2011, the MCO must consider all bills it receives within 1 year of the service date eligible to consider for payment. Such bills are also eligible if they are submitted within 1 year of the date on which the bill became payable due to a final adjudication order or SHO order, whichever is later. If this date is more than one year after the service date, the MCO must submit the bills priced at \$0.00 to BWC and then request that they be adjusted.
- In cases where the claim status date or condition status date is used as the receipt date and that date is more than 2 years past the service date for bills with a date of service prior to July 29, 2011, or more than 1 year past the service date for bills with a date of service on or after July 29, 2011, the MCO must price the affected lines at \$0 and attach the 125 EOB. Following adjudication by BWC the MCO must request an adjustment to override this edit.

Bill Processing Options

The MCO must process all bills within 7 business days of receipt from the provider. Bills may be rejected, pending or transmitted to BWC.

a. Rejecting Bills - MCOs may reject a bill and return it to the provider if the bill meets the bill rejection criteria outlined below. The MCO shall keep a copy of and track all rejected provider bills. The MCO shall notify the provider of the rejected bill using the appropriate EOB code. Rejected bills must be sent to the attention of the “workers’ compensation section” of the provider’s “Billing Department.” When rejecting bills, whether manually or systematically, the MCO shall include the following information at a minimum:

- Claim number
- Provider number
- EOB including narrative
- Patient control number
- Date of the rejection letter

Bill Rejection Criteria:

- **Incomplete bills** - Bills that are missing any of the mandatory data elements that BWC requires on the 837 are considered incomplete. An example of this is a bill without a claim number. The MCO must submit all mandatory and optional 837 data elements submitted by the provider as described in the Information Systems Documentation and the remainder of this chapter. If submitted to BWC with incomplete data, a bill would be rejected by BWC on an 824 with EOB 989 (payment denied – claim number omitted – resubmit). If the bill is missing one of the mandatory data elements, the MCO may attempt to obtain the information from the provider or reject the bill. The missing mandatory data elements on the incomplete fee bill must be identified by the MCO prior to returning the bill.

- Bills with invalid data - Bills that contain invalid data elements (e.g. “ABC” is not a valid ICD-9 diagnosis code) shall be rejected. If a bill was submitted to BWC with this invalid code, BWC would reject it on an 824 with EOB 344 – payment is denied as billed diagnosis is invalid.
- Duplicates of bills that were previously paid or are currently in process – MCOs shall reject duplicate bills as defined below:

Non-facility bills

- the same injured worker (the same Social Security number);
- the same date of service;
- the same service;
- the same servicing provider.

Note: Services that are payable according to policy (e.g. provider reimbursement in multiple claims policy) shall not be rejected as duplicates.

Facility bills

- the same injured worker (the same Social Security number);
- the same covered dates;
- the same provider number.

Note: hospital late charges shall not be rejected; they must be processed as adjustments according to the procedures in this manual.

b. Pending Bills - If the claim associated with the bill or a condition billed for that claim is in a pending status, **including pending settlement**, MCOs shall pend the bill until the claim or condition is in a determined status according to the following procedure:

- When the claim or condition is updated to a determined status, BWC notifies the MCO of the change via a 148 and the MCO must submit all pended bills to BWC within seven business days.
- The MCO must provide written notice to providers when their bills are pended because the claim or condition has not yet been determined.
- Determined claim statuses are: Allowed, Disallowed, Settled, Settled Medical, Settled Indemnity and Dismissed. Determined condition statuses are: Allowed, Disallowed and Dismissed
- Example: A bill is received on July 14, while the claim is in Allow/Appeal status so the MCO suspends the bill and sends notice to the provider. On July 28, the claim’s 14 day appeal period ends without an appeal so the CSS updates the claim status to Allowed. A 148 is sent to the MCO on the morning of July 29 (usually around 1 a.m.). The MCO applies the 148 to its system and the bill is released.

c. Transmitting Bills – Unless a bill meets the preceding rejection and pending criteria, the MCO shall review the bill for medical necessity and relatedness to the allowed conditions, apply the appropriate EOBs and transmit the bill data to BWC within 7 business days according to the following procedure:

- When submitting a bill to BWC, the MCO must submit all MANDATORY and optional 837 data elements submitted by the provider as described in the Information Systems Documentation and the remainder of this chapter.
- All ICD-9 diagnosis and procedure codes submitted by the provider must be included on the 837. For inpatient hospital bills, the ICD-9 diagnosis and procedure codes must be submitted **in the order** submitted by the hospital. Bills deemed non-payable but complete must be submitted to BWC; the MCO should price these bills at \$0.00 and submit the appropriate EOB.
- Line item amounts: if line item amounts are higher than BWC-determined thresholds, the MCO must verify that the amount is being transmitted correctly. If the amount is correct, the MCO must attach override EOB 025. Thresholds at implementation are:
 - \$100,000 on lines from inpatient bills
 - \$10,000 on lines from outpatient bills
 - \$10,000 on lines from professional (non-facility) billsIf the override is not present but the line item charge exceeds published thresholds, the line item will be denied and the MCO must verify that the amount was correct before re-submitting on the 837 with the appropriate override EOB. BWC will periodically review these threshold amounts and adjust them to better prevent erroneous amounts from being transmitted on the 837.

For further clarification, the following must be transmitted to BWC:

i. Bills for non-allowed, non-pending conditions

- If a diagnosis code on the bill is not in a disallowed, dismissed or pending status and has not been allowed in the claim, then the bill shall be transmitted to BWC.
- Non-allowed diagnoses (including codes on BWC's invalid ICD code list) on bills for services rendered within 72 hours of date of injury will pass through BWC's payment system and be reimbursed with the following EOB and message: EOB 530 - The date of service is within 72 hours of the date of injury so payment is being made for a diagnosis that is not allowed in the claim. BWC policy allows services rendered within 72 hours of the date of injury to be reimbursed even if the billed diagnosis is not an allowed code in the claim, or is on BWC's invalid code list.
- The MCO is still responsible for determining that the services were related to the industrial injury.

- Note: MCO may not use EOB 530 to reimburse an invalid code outside of the 72 hour time frame.
 - Bills with valid data
 - MCOs shall not reject any bill when the billed diagnosis and procedure codes are codes that appear in the ICD-9 and/or CPT manuals.
 - BWC's initial validation of the billed diagnosis code is not claim-specific. A billed diagnosis code will not be rejected on the EDI 824 transaction as long as the billed code appears in the ICD-9-CM manual.
- ii. Bills for disallowed conditions
- Bills received by a MCO for treatment of disallowed claims and/or disallowed conditions shall not be rejected back to the provider.
- iii. Medical documentation and bill processing
- Specific medical documentation may be needed with inpatient hospital bill submission. MCOs shall not regularly require providers to submit medical documentation for previously approved treatment. MCOs shall not reject bills or deny payment for previously approved treatment because medical documentation was not attached to a provider invoice, unless such documentation is necessary to price the service (e.g. unclassified/NOC procedures) or such documentation is required by the MCO in order to validate that the services billed are indeed consistent with the treatment that was requested and approved or in order to identify the services that were provided. Any requests for medical documentation made to the provider should be specific. That is, the request for additional medical documentation should specify date of service, type of service

d. Reviewing Medical Bills

The MCO shall have a process of reviewing medical bills that is integrated with its plan for RTW services. Treatment approvals/denials shall be integrated between the MCO medical management case notes/case management system and MCO bill payment system.

The MCO shall review medical bills according to the standardized prior authorization policy; BWC Billing and Reimbursement Manual and observe the 60 day presumptive approval policy. See Chapter 3 for additional information.

Medical Bill Retrospective Reviews

The MCO shall have in place policies and procedures for retrospective review of medical bills regardless of the provider type submitting the bill. The policies and

procedures shall include the criteria the MCO uses to determine the number of bills to be reviewed for each major category of provider type – inpatient hospital, outpatient hospital, ambulatory surgical center, and professional. The MCO, at its discretion, may use more detailed categories. The policies and procedures shall also include the frequency of the reviews (monthly, quarterly, etc.) and the criteria the MCO uses to select the sample of bills.

If the MCO requires additional medical documentation from the provider to complete its review, the MCO must request the needed documents from the provider. The MCO shall follow up with all action items (i.e. underpayments or overpayments) resulting from its reviews, following current BWC policies and procedures for adjustments and/or recovery.

Inpatient Hospital Admission Reviews

MCOs are required to complete prospective, concurrent and retrospective reviews for inpatient hospital admissions. All MCO prospective, concurrent and retrospective reviews shall be conducted by a nurse or certified coder.

Prospective Reviews

Prospective reviews shall be completed at the time the physician requests inpatient hospitalization. At a minimum, the review takes into consideration the necessity of admission, length of stay, intensity of service, and services requested in relation to the allowed ICD-9(s) and the MCO's use of the Official Disability Guidelines. Prospective reviews may also consist of physician reviews; include discussions with injured worker regarding expectations on recovery and outcomes including facilitation of pre-op testing and scheduling to minimize lost-time; may include discussion with the treating physician regarding expected outcomes and pre/post op planning; and may result in a system flag to identify potential high dollar services.

Concurrent Reviews

Concurrent reviews shall be completed during the injured worker's inpatient hospital stay and shall evaluate the necessity of admission, length of stay, intensity of service, and services provided in relation to the allowed ICD-9(s) and treatment guidelines, unexpected outcomes (e.g. complications). For example, the MCO should be communicating with the hospital as to why a length of stay exceeds treatment guidelines. While the DRG methodology does include an internal mechanism which discourages excess stay, DRG is still a reimbursement methodology, not a medical management tool. Additionally, some hospitals are DRG exempt and some bills pay at an outlier rate, so the question of appropriate length of stay continues to exist and must still be managed by the MCO. Since the estimated length of stay provided on the request for treatment is the primary trigger for establishing the concurrent review schedule, it must still be addressed by the MCO.

Retrospective Reviews

The Inpatient Hospital Reimbursement Policy requires MCOs to conduct retrospective reviews of certain inpatient hospital bills. The purpose of these reviews is to ensure that services which have been paid are related to the allowed conditions in the injured workers' claims, to verify that services billed are documented in the medical records and to audit line item charges for possible errors.

e. Resubmitting Rejected or Denied Bills Due to MCO Error

In the event that an MCO rejects (bill returned and not submitted to BWC) or an MCO denies (bill submitted to BWC) a bill in error, the MCO shall resubmit its copy of the original bill with the original MCO receipt date. **The MCO shall not request another copy of the bill from the provider.**

Bills rejected or denied in error include but are not limited to the following:

- Bills denied for lack of authorization when the provider received authorization for the services billed;
- Bills denied or rejected for missing or invalid data when appropriate data was submitted in the proper format (example - provider number) or when data was not required (example - CPT codes on inpatient bill);
- Bills rejected and not sent to BWC when bill does not meet rejection criteria (disallowed claims, duplicates or bills that would not pass through API);
- Bills denied for non-allowed diagnosis when the diagnosis billed and diagnosis allowed fall within the same clinical diagnosis group.
- Bills denied for non-allowed diagnosis when the diagnosis billed is related to the allowed conditions and the date of service is within 72 hours from the date of injury.

Important: The MCO shall not reject or hold bills due to lapsed provider certification. Bills denied due to lack of certification can be re-submitted by the provider once the provider becomes recertified.

3. Transitions

In the event of any transition (i.e. merger/acquisition, open enrollment, auto-assignment due to contract termination) all bills go to the assigned MCO as of the effective date of the transition. However, if the former MCO receives a bill after the transition date and has enough information to process the bill then it should process it. BWC's payment system will support this procedure and process the bill appropriately. It is the assigned MCO's responsibility to contact the former MCO where the claim was previously assigned in cases where there is not sufficient information to process the bill.

4. Electronic Billing

All MCOs are required to receive 837 EDI medical bill transmissions from medical providers. MCOs shall promote electronic billing by providers. Within seven calendar days of receiving payment from BWC, the MCO will send the payment to the provider.

a. Hospital Late Charges

Hospital late charges cannot be submitted by MCOs to BWC as 837 EDI medical bill transmissions. Instead, the MCOs must submit a request for adjustment of the initial bill. The MCO must include documentation of the hospital's bill for late charges with the adjustment request. This documentation can be a hard or soft copy (fax, email) of the UB-04 if submitted to the MCO in that format. If submitted to the MCO electronically (EDI, NSF, etc), a screen print from the MCO's system of the late charges is acceptable as long as the information is easily understood or accompanied by an explanation of the screen print.

5. Status of Provider Bills

The MCO is required to send an explanation of benefits (EOB) to the provider for every line item on a bill that was denied payment. The MCO shall have and use a system that tracks the status of provider bills at any stage of the bill adjudication process. Such a system must allow the MCO to respond to inquiries by authorized parties and BWC as to the disposition of a bill and the expected payment date. Upon request from BWC, the MCO will be required to issue reports to the BWC and/or medical providers on the status of payments to providers.

Remittance Advice

- The MCO is responsible for notifying the provider about the final adjudication of a bill, including payment approvals and denials. Information that a *remittance advice* shall contain (at minimum) from the MCO to the provider includes:
 - Provider name and address
 - Provider and payee number (with first five digits masked)
 - Claim number
 - Injured worker name
 - BWC Invoice Number (18 digit number)
 - Patient account number
 - Date of service
 - Revenue code for hospital bills
 - Procedure code on outpatient hospital bills and bills for all other provider types
 - Modifiers
 - Line item units of service
 - Line item amount billed

- Line item amount allowed
- EOB code(s) and explanation(s) – the only EOB codes that should be listed on the provider’s remittance advice are the ones received from BWC on the 835
- Billed total
- Interest amount
- Paid total
- BWC-assigned DRG on hospital inpatient bills – the DRG used in pricing the bill from BWC on the 835
- BWC-assigned APC code for each line on hospital outpatient bills

6. Provider Education

The MCO is the provider’s primary point of contact for all medical billing issues. The MCO shall never tell providers, injured workers, or employers to call BWC about a denied bill. The MCO shall help the provider understand why the bill was denied and what steps the provider should take to resolve the issue. If the MCO is unsure about the reason for a denial, it should call its Medical Billing and Adjustment Unit contact for clarification. MCO shall educate providers, both in-state and out-of-state, on correct billing procedures and the MCO’s prior authorization methods as well as electronic bill submission.

a. Out-of-State Providers

Out-of-state, non-BWC certified providers who are not willing to provide services to an injured worker at BWC’s fee schedule may be considered for payment at UCR charged amount. However, the MCO will conduct thorough research to determine usual, customary and reasonable charges and will attempt to negotiate a fee at the fee schedule or as close to the fee schedule as possible. The MCO may submit the bill for payment and then request an adjustment with EOB 860, for additional or UCR charged amount reimbursement.

b. Out-of Country Providers

When an MCO receives an invoice for services rendered outside the U.S. and its territories, the MCO has the responsibility to verify the currency in which the provider has billed. If the billed amount is not in U.S. currency, the MCO *must* convert the billed amount into U.S. dollars before the bill is submitted. The conversion rate used should be the rate valid on the date of service. This information may be obtained from a bank or from an appropriate publication or website. The MCO is responsible for helping the out of country provider with the necessary coding and billing forms to allow for payment of services. If the provider is requesting reimbursement of more than twice the BWC fee schedule the MCO must enter a note into the claim and contact Medical Policy for processing of the MCO approved rate.

7. MCO Inquiries submission to Medical Policy via MedPol mailbox

a. Payment above fee schedule

When unusual circumstances justify payment above the fee schedule, the MCO may need to submit supporting documentation regarding the MCO's approval. Submission of MCO approval information is received through BWC's Medical Policy Department. The service/supply must be reviewed by the MCO and determined to be medically necessary and appropriate.

Inquiries must be submitted on a word document template via email to **Medpol@bwc.state.oh.us** in accordance with the BWC sensitive data policy before payment will be released to a provider.

This applies to any service/supply that is not eligible for use of EOB 752 under the bill processing protocol of BR/NC/NRC codes set forth below, and in the following situations if the requested fee is more than twice the fee schedule.

i. In-state, certified providers must accept the BWC fee schedule for CPT codes, ASC levels and hospital in-patient and out-patient services. However, unusual circumstances may justify payment above BWC's maximum allowable rate to an in-state provider for Level II and Level III HCPCS coded services/supplies. These codes usually are assigned By-Report, per diem or negotiated fees. However, the MCO must document and submit information detailing the unusual circumstances which warrant consideration of payment above fee schedule.

ii. If an out of state provider is requesting reimbursement of **more than twice** the BWC fee schedule, the MCO must enter a note into the claim that documents the case management efforts that lead to the request for the payment. Prior to requesting an adjustment, the MCO shall complete all necessary research and documentation supporting their decision to pay above fee schedule. MCOs are required to: document attempts at locating a certified provider and document all research efforts regarding fees & attempted negotiation of fees.

b. BR/NRC/NC coded services

BWC has expanded EOB 752 for use in the following billing scenarios:

Professional Provider Medical Services Fee Schedules beginning 2/19/2009 forward:

A. All HCPCS NC (prior to 10/25/10), NRC & BR codes listed as \$0.00 provided:

1. The reimbursable amount is \$750.00 or less; or
2. J codes are accompanied with a pharmacy invoice and the amount will be equal to 20% or less of the invoice.

B. CPT and HCPCS NC or BR codes prior to 10/25/10 and NRC or BR codes after 10/25/10 provided those codes show an assigned fee schedule amount posted on the Professional Provider Medical Services Fee Schedules from 10/25/10 forward.

Please note: EOB 752 may also be used for facility services associated with provider services for which provider bills have been processed under EOB 752, as long as those coded services are payable to facilities. If a code is never reimbursed to a facility, example: not shown on the ASC fee schedule, then EOB 752 cannot be utilized even if a provider bill is paid. This process does not affect bills subject to OPPS.

Any code not falling into the above scenarios will continue to be processed according to current NC, NRC & BR protocols. **Please note this action is applicable to adopted Professional Provider Fee schedules starting with 2/19/09 forward.**

When EOB 752 is used, bills will no longer require front-end verification by BWC Medical Policy, but will be verified via back-end audits. In all cases, MCOs will still be required to document the pertinent elements in the claim. The MCOs must continue to document how Miller criteria are met and to maintain supporting documentation, including research that confirms the correct code was billed, cost analysis information, negotiation attempts, and clinical rationale for authorization. Unsupported or inappropriate reimbursement authorization decisions can result in negative audit findings for which the MCO may be held financially accountable.

When an MCO has determined that unusual circumstances justify payment of a BR or NRC coded service and that code does not fall under the use of the EOB 752 guidelines above, the MCO is required to submit the MCO approval information through the MedPol mailbox for processing of the MCO reimbursement.

Please note that the 2010 fee schedule includes changes to BWC’s coverage terminology. Under the 2010 fee schedule (effective October 25, 2010), “NC” means “Never Covered”, and such codes will not be covered unless ordered by the IC. Therefore, for dates of service on or after October 25, 2010, for those services designated as “NC”, EOB 752 cannot be used by the MCOs to authorize payment.

The 2010 fee schedule also introduced the new designation of “NRC” (“Not Routinely Covered”). For those services designated as “NRC”, EOB 752 can be used according to the protocols outlined above. Effective with the 2010 fee schedule, BWC will use EOB 553 to deny codes designated as NC. Additionally, BWC will use EOB 395 to deny codes designated as NRC if the MCO submits the bill with a to-be-paid amount but did not attach the EOB 752 override.

The MCO must provide to Medical Policy written, supportive documentation which substantiates the adjustment amount. It is the responsibility of the MCO to research and justify the increased costs by performing cost comparisons and negotiating directly with the provider prior to submitting the MCO information through Medical Policy. Any research information, invoices or other pertinent documentation must be imaged into the claim.

The following list of elements, in conjunction with the templates and template instructions, are required to be submitted by the MCO with each BR/NRC or payment above fee schedule inquiry (for added clarity, template and template instructions can be found on the MCO portal):

- injured worker's name
- injured worker's claim number
- description of the service/supply being authorized by the MCO
- code(s) being utilized for billing purposes
- rationale for increased reimbursement request
- date of service and/or timeframes, when applicable
- provider's name and provider number
- If a bill has not been submitted, the MCO must provide the dollar amount being requested by the provider and the negotiated dollar amount to be paid
- date the C-9 was approved for the service/supply
- If a bill has been paid and/or submitted, the MCO must supply to Medical Policy the BWC Invoice Number with each line item(s) detailed to avoid possible discrepancies. These details will include but not be limited to the BWC Invoice Number, line item of the adjustment being requested, billing code, DOS, amount billed, amount paid and the balance amount the MCO is requesting to be paid
- Research of cost comparisons including, but not limited to documentation of contacts with other similar providers/vendors and results of the cost comparison and
- Explanation of the unusual circumstances requiring the specific service/supply. In some situations the documentation/invoice from the provider indicating the provider's cost for the supply/service may be necessary and must be obtained
- documentation of negotiations and conversations with the provider and results

Processing an MCO bill or adjustment inquiry does not constitute BWC agreement to the determination made by the MCO. A MedPol V3 note is not an authorization of service, codes or fees but instructs the MB&A Department to process an MCO adjustment to pay. This payment may be subject to MCO recovery if found to be inconsistent with current health care provider payment standards and industry practices or in conflict with law, rule, or the MCO contract.

What is the difference between an MCO request for payment above the fee schedule before a bill is received and before or after the bill has been submitted to BWC's billing system?

1) Requesting approval for a reimbursement amount before the service has been provided:

This is the preferred method because the MCO will know if the request for payment above the fee schedule or reimbursement amount for a By Report code has been approved or denied before the IW receives the supply/service. In addition, the provider will receive the correct payment upon initial submission to BWC.

2) Requesting approval for a reimbursement amount before the payment has been made to the provider:

This method must be used for all bills received after following the process in 1) above. It must also be used for reimbursement of By Report codes where it was

not possible to submit information while negotiating a rate with the provider. It is also preferred for any situations where payment above the fee schedule is being recommended. In addition to following the documentation protocols and ensuring that all relevant documentation has been imaged, the MCO should attach EOB 717 “MCO requests this bill be suspended for BWC review” to the bill and submit with the recommended reimbursement amount. (Please note that use of EOB 717 is not limited to this scenario. It can be used any time a bill needs to be manually released by BWC due to special circumstances. Contact MB& A supervisors with questions at MBASUPV@bwc.state.oh.us.)

3) Requesting reimbursement adjustment after the payment has been made to the provider:

If the bill has already been paid at the BWC fee schedule amount, following MedPol V3 note instructions, the MCO must send an adjustment request to MB&A. The MCO must include EOB 876: “Payment above fee schedule to an in-state provider has been approved by BWC,” on the adjustment request or EOB 860: “Payment is for a negotiated fee to a non-certified, out-of-state provider.” EOB 876 is not an automatic override and will not allow payment above the fee schedule unless the overpayment has been -processed through Medical Policy and the MCO has provided proof of the V3 note.

8. Adjustments

The following guidelines were developed to assist MCOs in determining the appropriateness of requesting adjustments:

- a. Bills that are denied by BWC should be re-billed, not adjusted, if the reason for the denial can be addressed by the MCO.
- b. Most bills that are approved at \$0.00 on an 835 should be re-billed.

Exceptions to this include:

- Bills for claims in pending settled.
- Bills that denied as a result of newly discovered and uncorrected BWC system errors. BWC reports new incidences to MCOs via billing updates that include suggested workarounds.
- Bills denied as duplicate. When requesting an adjustment for a duplicate EOB edit, MCOs must provide justification (written explanation of the reason for request) and appropriate duplicate EOB on the adjustment form. The justification must detail why the adjustment will not result in a duplicate payment. The MCO should provide the CIN of the bill that caused the duplicate denial. This will demonstrate that the MCO has researched the denial and found t to be invalid. Adjustments that do not meet these requirements will be rejected.
- **Note:** Bills for which some lines paid, however, the MCO determine \$00.00 priced/paid lines are appropriate to adjust (MCOs should not submit a new bill for payment resolution).

Note: Previously, bills for OD claims when the date of service was before the date of injury were denied with EOBs 450 and 244. These bills had to be adjusted or manually entered. BWC developed an enhancement so that these bills can be processed automatically. The MCO must use override EOB 783 to submit bills for reimbursement in these cases.

- c. Voids (a.k.a. reversals) should be requested for bills that are not to be reissued. This type of adjustment is intended to recover overpayments, not to fix incorrect payments. BWC cannot adjust the voided bill, nor can the MCO routinely resubmit the bill. The most frequent reasons to void bills are
 - Duplicate payments;
 - Payments for services that are not and will not be authorized;
 - Payments made for the wrong claim number.
- d. If an MCO receives reimbursement from a third person or party, it must submit a request for adjustment to BWC to void the bill. If an MCO is going to reimburse an employer, it must submit an 837 with valid BWC servicing and pay-to provider numbers and EOB 772 - MCO IS REIMBURSING EMPLOYER FOR THESE SERVICES. The 835 will still indicate payment to the provider but the EOB is the MCO's guide to how payment should actually be made.
- e. The MCO shall submit provider billing adjustment requests to the BWC within ten (10) Business Days of receipt or within such other time frame as may be specified by BWC.
- f. Adjustments must be requested on the Request for Adjustment form and may be submitted by:
 - E-mailing to the HPP Adjustments mailbox at hpp.adjustments@bwc.state.oh.us;
 - Faxing to the attention of HPP Adjustments at (614) 621-3135
 - Mailing to BWC Medical Billing and Adjustment Unit, 30 W. Spring St. 20th floor, Columbus, Ohio 43215. **Please do not send adjustment requests to your assigned Medical Billing and Adjustment Unit representative unless specifically requested to do so.**

Adjustments for Hospital Inpatient Bills

Adjustment requests submitted for DRG paid inpatient hospital bills must include "Inpatient Bill Adjustment" in the reason for request field on the adjustment form. In order to ensure that adjustments on DRG paid inpatient hospital bills are timely identified and appropriately processed, late charges and adjustments for DRG paid inpatient hospital bills should only be e-mailed to Medical Billing & Adjustments at: MBADRG@bwc.state.oh.us. Adjustment requests for potential retrospective recovery adjustments should be submitted to MBADRG@bwc.state.oh.us to be run through the BWC billing test system to determine the appropriate recovery amount.

Adjustments for Hospital Outpatient Bills

MCOs cannot split a bill into multiple bills for one span of dates of service for the same encounter. If an MCO submits unpaid lines from an original bill with one or more paid lines, the bill will be denied as a duplicate. The first bill must be adjusted in order to pay the unpaid lines. Only the original bill can be adjusted.

In cases where the MCO determines that lines have been paid in error and there is a potential recovery situation, the adjustment must first go through test to determine the exact overpayment amount. The adjustment should be submitted to MBASUPV@bwc.state.oh.us. On the top of the adjustment form should be written: **OPPS TEST ADJUSTMENT**. MCOs do not need to fill in the *money recovered/refunded* box on the adjustment form. MCOs should clearly indicate on the form what data element(s) are changing that may result in a payment reduction. Medical Billing and Adjustments will communicate the results back to the MCO. Once BWC sends the results back to the MCO, the MCO can proceed with the recovery process. Post recovery, the MCO will resubmit the adjustment with the box *money recovered/refunded* completed. Please note on the adjustment form that the overpayment test was already completed to expedite the processing of the recovery.

- g.** A request from the MCO to override EOB 125 (2 year statute) must provide the following information on the adjustment request: A previous CISGI (CAMBRIDGE) Invoice number showing receipt within 2 years or proof of submission to the MCO for bills not submitted by the MCO to CAM. This proof of submission would be proof of timely receipt by the MCO as evidenced by a date stamp by the MCO. The exception would be for billing that meets the requirement of submission within six months from the date of the mailing of the final order of allowance of claim. In that case please attach a copy of the order justifying timely submission of the bill with the adjustment. If these requirements are not met the adjustment will be rejected.
- h. A request to increase the provider charges on a bill due to a provider billing error requires a copy of the revised bill to be submitted with the adjustment request.**

 - i.** If you are uncertain about how to request specific changes, please contact the HPP Adjustment Area at (614) 995-0454 before completing the Request for Adjustment form or contact your assigned representative directly with questions
 - j.** Do not attach various other documents with the adjustment form other than what is already outlined in the MCOPRG unless specifically requested by MB&A. Whenever possible please keep the adjustments to one page. When the adjustment (and any attached documents) are more than one page make sure the pages are numbered.
 - k.** Money returned to the MCO as the result of an adjustment must be deposited into the MCO's provider bank account as soon as possible with a deposit date no later than two business days post receipt.
 - l.** MCOs may receive 835 remittance advices for "history only" adjustments. These are adjustments that are made to reflect a change in the bill that does not result in monies being paid or recovered. For example, a "history only" adjustment may be made to charge a paid bill to the surplus fund if a previously allowed claim is later disallowed. In that instance, money is not taken from the MCO/provider but the payment record is revised to remove the charge from the employer's policy. There will be an indicator on the remittance to alert the MCO that the adjustment is "history only."

- m.** MCOs may also receive adjustments to invoices that they did not submit to BWC. This will occur when an MCO merger/acquisition takes place and bills submitted by the original MCO are later adjusted. These adjustments will be recognizable on the 835 remittance advice because the submitting or original MCO will be identified and will be different from the MCO that received the adjustment.
- n.** The MCO shall track the status of all adjustments at any stage of the adjustment process. The MCO shall maintain a tracking log (i.e. spreadsheet) that contains, but is not limited to, the following information:
- Date the MCO was first notified adjustment was necessary
 - Method of notification (MCO receive phone call from provider? Check returned uncashed with overpayment letter?)
 - Date MCO sent adjustment to BWC
 - Date MCO received respective 835 containing adjustment
 - Date underpayment was issued to provider
 - Date contact was made with provider notifying of overpayment
 - Date provider submitted overpayment back to MCO
- o.** If the MCO determines that an adjustment is required to pay additional money to the provider, the MCO will not require the provider to return the entire paid amount in order to process the adjustment.
- p.** If the MCO determines that an adjustment is required to take back additional money from the provider, the MCO will recover the exact amount of the overpayment from the provider prior to submitting the adjustment. The MCO will not require the provider to return any money that should be paid to the provider for the purpose of processing an adjustment. The exception to the upfront recovery of overpayments applies to inpatient and outpatient adjustments that are required to be run through test to determine the exact amount of recovery.

9. Claim and ICD-9-CM Status

Claims status refers to the status of the claim after the CCT or the IC has made a determination on the claim. Determinations may occur throughout the life of a claim due to initial allowance, additional allowance, aggravation, etc. BWC will report to the MCO via the 148 transmission the status of the claim. This data element may be transmitted several times by BWC to the assigned MCO during the life cycle of the claim.

ICD-9-CM status refers to the status of the ICD-9-CM code(s) that were considered for allowance on the claim. Upon determination of compensability of the claim, BWC will transmit to the MCO via the 148 transaction set, the status of the injuries considered by BWC for the claim. This data element may be transmitted several times via 148 transmissions to the MCO throughout the life of the claim.

The following matrix further defines each claim and ICD-9-CM status type and indicates when bills can be submitted:

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
NC = New Claim	Not an ICD-9 Code status.	Status assigned by the system when claim is added to the system and no ICD-9 code has been attached to the claim.	No	No	Claims in NC status will remain active.
AG = Alleged	Status used when an ICD-9 code is being investigated during the initial determination phase or when ICD-9 code is added to claim while it is being investigated. ICD-9 codes not to be either allowed or denied should not remain in AG status on the claim, they should be deleted.	When all ICD-9 codes on the claim are in AG status, the claim is also in AG status. This claim status indicates that the claim is under investigation.	When claim is in AG status, compensation is not payable.	When claim is in AG status, medical bills will not pay. When the claim is allowed and there are ICD-9 codes in AG status, bills for that ICD-9 code will not pay.	Claims in AG status will remain active. Claims in allow or disallow status with ICD-9 codes in AG status can become inactive. ICD-9 codes can be added in AG status on inactive claims without making the claim active.

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
AA= Allow/ Appeal	This status is used when a decision has been made by BWC to allow an ICD-9 code and an order will be issued. ICD-9 codes in AA status will appear on the initial allowance and subsequent decision orders (except for death orders).	The claim will be in AA status when there is at least one ICD-9 code in AA and no other ICD-9 codes are in allow or deny status.	When claim is in AA status, compensation is not payable. Compensation is payable if the claim is in allow status but there are ICD-9 codes in AA status.	When claim is in AA status, medical bills will not pay. When the claim is allowed and there are ICD-9 codes in AA status, medical bills will not pay for the conditions in AA.	Claims in AA status will remain active. Claims in allow status with ICD-9 codes in AA can change to inactive. ICD-9 codes can be updated to AA status when the claim is inactive without making the claim active.

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
DP= Disallow/ Appeal	This status is used when a decision has been made by BWC to disallow an ICD-9 code and an order will be issued. ICD-9 codes in DP status will appear on the initial decision order (except death orders).	The claim will be in DP status when there is at least one ICD-9 code in DP and no other ICD-9 codes are in AA, allow or deny status.	When claim is in DP status, compensation is not payable. Compensation is payable if the claim is in allow status but there are ICD-9 codes in DP.	When claim is in DP status, medical bills will not pay. When the claim is allowed and there are ICD-9 codes in DP status, medical bills will not pay for the conditions in DP.	Claims in DP status will remain active. Claims in allow status with ICD-9 codes in DP can change to inactive. ICD-9 codes can be updated to DP status when the claim is inactive without making the claim active.

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
HR = Hearing	<p>ICD-9 codes are updated to hearing status when an appeal has been timely filed to the BWC order allowing or disallowing the ICD-9 code. They should remain in HR status until the hearing process is complete, unless this is the initial claim allowance and compensation is granted by the DHO. If an appeal is filed outside of the appeal period, the status should not be updated to Hearing until a referral has been made to the IC.</p> <p>This status is to be used for both initial and subsequent decisions. When a request for allowance of an additional condition has been referred to the IC for determination, the ICD-9</p>	<p>The claim will be in HR status when at least one ICD-9 code is in hearing status and there are no ICD-9 codes in allow/appeal, disallow/appeal, allow or disallow status.</p> <p>This status is not used when the claim determination is under appeal to the court. The last decision made by the IC should be recorded as the ICD-9 status when a claim is appealed to court.</p>	<p>Compensation is not payable when a claim is in HR status.</p> <p>Compensation will be stopped if it is paying at the time a claim is updated to HR status. If TT is being paid in a claim that is being sent to hearing, the current TT plan must continue to be paid unless stopped by IC order. (The plan should not be extended once the determination of the claim is going to hearing.) In order to allow the current plan to continue to be paid the claim should be updated to allow, then hearing, then DHO hearing and the TT plan will be rebuilt. Once the current TT plan has ended if no decision has been made by the IC, the claim can be updated to HR status.</p> <p>Compensation is not payable if the claim is in allow status but there</p>	<p>Medical bills are not payable when a claim is in HR status.</p> <p>If the claim is in allow status, medical bills will not pay for the conditions in HR status.</p>	<p>Claims in HR status will remain active.</p> <p>An ICD-9 code can be updated to HR status while the claim is inactive without making the claim active.</p> <p>Claims in allowed status with ICD-9 codes in HR status can change to inactive.</p>

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
HD= DHO Hearing	ICD-9 codes are updated to HD status when the claim has been allowed by the DHO and compensation has been ordered. HD status should only be used when the initial allowance of the claim has been made by the DHO and compensation has been ordered. Once a claim has been allowed, HD status is not appropriate because compensation will be payable because the claim is allowed and medical bills should not be stopped for the allowed conditions in the claim.	The claim will be in HD status when at least one ICD-9 code is in DHO hearing status and there are no ICD-9 codes in allow/appeal, disallow/appeal, allow or disallow status.	Compensation can be paid when a claim is in HD status.	Medical bills are not payable when a claim is in HD status.	Claims in HD status will not become inactive. ICD-9 codes can be updated to HD status when a claim is inactive. The claim will change to active and a diary will be posted to the team leader's work list.

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
AL= Allow	<p>This status is used after the decision to allow an ICD-9 code is final.</p> <p>It is also used when the IC has issued an order to allow an ICD-9 code and that allowance has been appealed to the court.</p>	<p>If at least one ICD-9 code for a claim is in AL status, the claim will be in AL status.</p> <p>If a claim is certified by the employer it can be updated to allow without waiting until the end of appeal period.</p> <p>Claims allowed as Fast Response claims will be updated to AL status without waiting until the end of the appeal period.</p> <p>Allow is also used when the SHO has issued an order to allow a claim and the claim allowance has been appealed to the court.</p>	Compensation is payable when a claim is in AL status.	Medical bills are payable for the ICD-9 codes in AL status.	<p>Claims in AL status will become inactive when the criteria for an inactive claim have been met.</p> <p>ICD-9 codes can be updated to AL status when a claim is inactive. The claim will change to active and a diary will be posted to the team leader's work list.</p>

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
DA= Disallow	<p>Status used after decision to disallow ICD-9 code is final.</p> <p>Also used when IC has issued an order to disallow and decision has been appealed to court.</p> <p>This status is also used for an ICD-9 code when a claim has been partially settled for an ICD-9 code.</p> <p>DA status is used when a claim is dismissed by the IC after compensation has been paid.</p>	Claim status will be disallow if no ICD-9 codes in allow status and at least one ICD-9 code in DA status.	Compensation is not payable when a claim is in DA status.	<p>Medical bills will not pay when a claim is in DA status.</p> <p>If a claim is in allow status, medical bills will not pay for ICD-9 codes in DA status.</p>	<p>Claims in DA status will become inactive when the criteria for an inactive claim have been met.</p> <p>ICD-9 codes can be updated to DA status on inactive claims without making the claim active.</p>

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
DS = Dismiss	<p>ICD-9 codes are placed in DS status when the IW has requested that the application for a claim be dismissed. All ICD-9 codes for a claim should be placed in DS status, except for the case where the IC orders a condition be dismissed on a previously allowed claim.</p> <p>If an IW withdraws an application for a subsequent allowance, the condition is not placed in DS status; it should be deleted from the claim.</p>	<p>The claim status will be dismiss if there is a single ICD-9 code in DS status and there are no ICD-9 codes in allow/appeal, allow, disallow/appeal or disallow statuses.</p> <p>The claim cannot be updated to DS status if compensation has been paid. If the IC orders a claim dismissed after compensation has been paid the disallow status is used.</p>	<p>Compensation is not payable when a claim is in DS status.</p> <p>Any compensation paid in a claim that is to be dismissed must be vacated.</p>	<p>Medical bills are not payable when a claim is in DS status. If the claim is in allow status, medical bills will not pay for ICD-9 codes in DS status.</p>	<p>Claims in DS status will become inactive when the criteria for an inactive claim have been met.</p> <p>ICD-9 codes can be updated to DS status on inactive claims.</p>

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
SM= Settled Medical	This is not an ICD code status.	The claim status changes to SM when the settled medical date is entered and no settled indemnity date has been entered.	Compensation is payable when the claim status is SM. Note: Some correspondence will not be available when a claim is in SM status. It may be necessary to issue the correspondence via ad hoc or offline.	Medical bills are not payable when the claim status is SM.	Claims in SM status will become inactive when the criteria for an inactive claim have been met. Claims must be active in order for the SM date to be entered.
SI = Settled Indemnity	This is not an ICD code status.	The claim status changes to SI when the SI date is entered and no settled medical has been entered.	Compensation is not payable when a claim is in SI status. Benefits plans are automatically closed when the claim status is SI. Note: Some correspondence will not be available when a claim is in SI status. It may be necessary to issue the correspondence via ad hoc or offline.	Medical bills are payable when a claim is in SI status.	A claim in SI status will become inactive when the criteria for an inactive claim have been met. Claims must be active in order for the SI date to be entered.

Status	Status applied at ICD-9 level	Status applied at claim level	Compensation payment	Medical payment	Active/Inactive Comments
ST= Settled Both	This is not an ICD code status.	The claim status changes to ST when both the medical and indemnity settlement dates are entered.	Compensation is not payable when a claim is in ST status. Benefit plans are automatically closed when the claim status is ST.	Medical bills are not payable when a claim is in ST status.	Claims in ST status will become inactive when the criteria for an inactive claim have been met. Claims must be active in order for the settled medical and settled indemnity dates to be entered.

10. Bills Submitted on Treatment Requests Currently in the ADR Process

Bills submitted on treatment requests currently in the ADR process shall be denied with the appropriate ADR denial EOB code. If the services are later authorized, the MCO shall use the appropriate EOB code and request an adjustment on the denied bills.

The MCO should use the following, appropriate EOBs on bills submitted for treatment requests currently in the ADR process include:

***EOB 537:** MCO Alternative Dispute in process for services requested. Services are not payable at this time.*

***EOB 538:** Treatment reimbursement approved by MCO Alternative Dispute process (no appeal) - adjustment done to process previously disputed services.*

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at MCO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 537 EOB. If the services are later authorized at the MCO level, and the decision is not appealed to the BWC, the MCO may use the 538 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

***EOB 539:** MCO decision on ADR issue was appealed to the BWC. Services are not payable at this time.*

EOB 540: Treatment reimbursement approved by BWC (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at BWC level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 539 EOB. If the services are later authorized at the BWC level, and the decision is not appealed to the DHO, the MCO may use the 540 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

EOB 541: BWC decision on ADR issue appealed to DHO. Services are not payable at this time.

EOB 542: Treatment reimbursement approved by DHO (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the DHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 541 EOB. If the services are later authorized at the DHO level, and the decision is not appealed to the SHO, the MCO may use the 542 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.

EOB 543: DHO decision on ADR issue appealed to SHO. Services are not payable at this time.

EOB 544: Treatment reimbursement approved by SHO (final determination) - adjustment done to process previously disputed services.

Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the SHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 543 EOB. If the services are later authorized at the SHO level the MCO may use the 544 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills.

a. Arth Brass

The ruling in the Arth Brass case stated that BWC may not charge medical payments to an employer's risk account until after there has been a final administrative or judicial determination. An "Appealed to IC/Court" yes/no indicator has been added to the *Claims Status* screen on BWC's Web site on 2/13/06 but is not yet available.

The Arth Brass decision applies to any issue that determines whether associated medical benefits are payable. The Court held that while the Bureau may pay medical benefits after an SHO order, it cannot charge an employer's experience until a final adjudication. The court did not designate that the final adjudication had to be that of the initial allowance of the claim. Therefore, it would apply to specific requests, including but not limited to, to pay medical

benefits (ADR) as well as to pay medical benefits associated with a claim for an additional allowance.

11. 1099 Reporting

MCOs are required to report miscellaneous payments, made on behalf of BWC to providers, to the Internal Revenue Service (IRS). The MCO verifies, corrects and resolves any incorrect tax identification numbers (TIN) the IRS identifies. Backup withholding and/or payment denial is the responsibility of the MCO as a result of any TIN reported incorrectly to the IRS. After obtaining the W-9 form from the provider, the MCO should check the BWC provider data file to see if the current information on the file matches the information on the W-9 or the change of address form. If the information matches **do not send** the W-9 or change of information to BWC as BWC has the current correct information on the provider file. If the information **does not match** please fax the W-9s or change of information forms to the Provider Relations Department at (614)621-1333. MCOs are required to honor IRS tax levies issued against providers to whom they have issued a 1099. IRS orders supersede orders issued by BWC.

12. Sales Tax Exempt

As a State of Ohio government agency, BWC is exempt from reimbursing any sales tax for tangible personal property and selected services provided to injured workers. Do not bill BWC for sales tax.

13. Provider Number

Providers of medical services to injured workers must have a BWC provider number to be eligible for reimbursement. An MCO who has approved services of a non-enrolled provider must facilitate the enrollment of the provider with BWC.

14. Penalty payment

MCOs are required to pay a penalty of ten dollars (\$10.00) to the provider for every instance in which the MCO denies a provider's bill due to lack of prior authorization and prior authorization either had been granted or was not required per standardized prior authorization and/or presumptive authorization guidelines table found in Chapter 1 of the Provider Billing and Reimbursement Manual on the date of service. The MCO is not required to make a penalty payment when a bill is inappropriately denied due to lack of prior authorization for *retroactive* medical service requests.

Penalty payments shall be paid from funds appropriated by the MCO and not from its provider bank account. The MCO shall issue payment to the provider within 14 calendar days upon discovery or notification of the inappropriate prior authorization denial. The MCO shall email BWC's HPP Inquiry Unit with the date and to whom the penalty payment was issued.

The following Q&A identifies some potential penalty payment situations:

Q: A provider submitted the same bill 3 times and all 3 bills were erroneously denied for lack of authorization. Is the MCO responsible for one \$10 payment or three \$10 payments (one for each denied bill)?

A: The MCO is required to pay "for every instance of erroneous denial," therefore; the MCO should pay three \$10 penalty payments or \$30.

Q: Is the provider entitled to the \$10 penalty payment if a bill was denied in error but then the provider resubmitted the bill and the MCO paid the bill?

A: Yes, the MCO is required to pay the \$10 penalty even if the bill was subsequently paid. This payment was meant to offset the provider's administrative burden when they are required to follow up with the MCO or resubmit a bill.

Q: Does the \$10 penalty apply when the Industrial Commission orders payment of treatment and the MCO denies the bill for lack of prior authorization?

A: Yes, the MCO is responsible for reviewing hearing orders and paying bills as ordered by the Industrial Commission.

Q: Is it ever appropriate to deny an office visit or consultation for lack of authorization?

A: Office visits and consultations (except for chronic pain programs and psychological treatment) never require authorization and therefore should never be denied for lack of authorization. The MCO should utilize a more appropriate EOB to accurately describe the reason for denial. The MCO will be required to pay the \$10 penalty payment for any office visit or consultation denied for lack of prior authorization.

Q: The MCO authorized a surgical procedure and then denied a line item related to that surgical procedure for lack of prior authorization? Is the MCO required to pay the \$10 penalty?

A: Yes, MCOs authorize specific procedures or treatment plans, not specific procedure codes. No procedure code related to the authorized treatment should be denied for lack of prior authorization; however, it may be appropriate to deny the line item with another EOB which accurately describes the reason for denial.

15. Subrogation

Subrogation is the right to recover from a third party or person the cost of benefits paid to or on the behalf of an injured worker in a worker's compensation claim. According to R.C. 4123.93 and R.C. 4123.931, BWC has the right of recovery from a third person or party for the cost of benefits paid or to be paid to an injured worker. The CCT and the MCO will assist BWC's customers (employers and injured workers) to recognize the subrogation potential of a claim during the investigation of the claim. BWC's Law Department handles this type of subrogation issue.

A second type of subrogation in which the MCO may become involved deals with third-party reimbursements.

a. Third Party Reimbursement/Subrogation Guidelines

According to Rule 4123-6-26, when the claimant or any other person making payment on behalf of the claimant, including a volunteer, pays for medical services or supplies directly to a health care provider not participating in the HPP or QHP and the claim or condition is subsequently allowed, the Payor shall be reimbursed upon submission of **evidence of the receipt and payment for that service or supply**. The Payor will receive the amount that would have been paid to the health care provider as provided by the rules of the Administrative Code.

When payment has been made to the health care provider, the Payor shall be informed to seek reimbursement from the provider.

Under Rule 4123-3-23, a fee bill to be timely filed must be filed either within one year from the date services were rendered or within six months from the date of the mailing of

the final order of allowance of claim, whichever period of time is longer, or be forever barred.

Parties who may request reimbursement from BWC or an MCO are:

- Injured Worker
- Employer
- Other 3rd Party:
 - Health Insurance
 - Union
 - Other Insurance
 - Hospitals* Provider type 60 (Other Third Party Payers) has been updated to include hospitals as a pay-to provider in this category.
 -

When an MCO receives a request from the injured worker, employer, or other third-party for reimbursement made for services or supplies that were allegedly not paid by BWC, the MCO should research its records to see if a bill has been previously received.

- If a bill has been previously received and paid, the MCO will notify the party requesting reimbursement to seek the reimbursement directly from the medical provider.
- If a bill has been previously received and not paid, but is now payable, and the party requesting the reimbursement is the provider of services, the MCO should process the request and reimburse the provider.
- If a request has been received for reimbursement for services/supplies rendered and paid for by the injured worker or employer, then the IW or employer making the request must supply a receipt and proof of payment for reimbursement consideration by the MCO. If, after review of the documentation provided, the MCO deems the request to be payable, the MCO should process the request and reimburse the injured worker or employer as appropriate. It may be necessary for the MCO to assist the injured worker or employer by contacting the provider to obtain the information necessary to process the bill.
- All 3rd parties must be registered/ enrolled with BWC so that payment can be made and 1099s can be sent at the end of the year. The MCO should contact Provider Relations for assistance in getting the 3rd party enrolled in the billing system so that they can be paid. BWC Law has approved BWC or the MCO assisting third parties in obtaining BWC provider numbers to facilitate the processing of medical bills.

When a third party health insurer requests payment for services that should have been covered by BWC, the amount of the payment is calculated as the lesser of the normal BWC allowance for that service/supply or the actual amount paid by the third party. The health insurer's request for payment must include two financial values for each service: a) the amount originally charged by the provider of the medical service; and b) the amount actually paid by the third party insurer.

All requests from the injured worker, employer, or other third-party for payment must include the following documentation/data elements:

UB-04	CMS 1500
BWC Claim#	BWC Claim#
Insured's Name	Insured's Name
Insured's SSN	Insured's SSN
Date of Injury	Date of Injury
Pay To Provider Name	Pay To Provider Name
Pay To Provider Address	Pay To Provider Address
Pay To Provider TIN	Pay To Provider TIN
BWC Provider ID# (Pay To)	BWC Provider ID# (Pay To)
Servicing Provider Name	Servicing Provider Name
Servicing Provider Address	Servicing Provider Address
Servicing Provider TIN	Servicing Provider TIN
BWC Provider ID# (Servicing)	BWC Provider ID# (Servicing)
First Date of Service	Date of Service
Last Date of Service	Place of Service
Place of Service	ICD-9 Code
ICD-9 Diagnosis Codes; ICD-9 Procedure Codes for Inpatient Bills	CPT/ procedure code, HCPCS Level II or Level III, if necessary
Revenue Code	Modifiers
CPT, HCPCS Level II or Level III	Units of service
Modifiers	Provider billed amount
Units of service	Third party paid amount
Provider billed amount	
Third party paid amount	

The insurer may submit copies of its remittance advice(s) or may submit the information electronically in a spreadsheet or similar document. The insurer must appear as the pay to provider. Effective 10/7/07, third party payers (Provider type 60) may be submitted as a pay-to provider type on hospital bills. The MCO must be able to flag all payments to third parties in its payment system in order to issue payment to the third party.

There are three (3) EOBs the MCO should use when processing these reimbursements:
EOB 771 – Injured Worker Reimbursements
EOB 772 – Employer Reimbursements
EOB 774 – Other 3rd Party Reimbursements

16. BWC Recovery Adjustments

a. What is a BWC Recovery Adjustment?

The normal flow of medical payments within HPP is through the MCO Provider account. When medical dollars are overpaid, MCOs recover the funds from the providers, deposit those monies into their medical provider account, and initiate the adjustment request via communication with BWC Medical Billing and Adjustment Unit.

In special circumstances, BWC determines and collects overpaid medical dollars directly from providers, bypassing the normal recovery method. One example is when the BWC Special Investigation Unit has collected following a fraud investigation.

The volume of BWC recovery adjustments is very low when compared to the vast number of bills processed by MCOs. However, this new functionality is necessary to properly account for the adjustments in MCO and BWC systems. If BWC has recovered an overpayment, and the MCO receives the recovery adjustment, it is important that the MCO does not at any later point try to collect the same overpayment, and equally important that the MCO does not write a check for the amount recovered.

b. Recovery Adjustments

BWC recovery adjustments are processed with regular bills and MCO initiated adjustments. Changes made to the 835 give MCOs several ways to identify and properly handle BWC recovery adjustments. Three new data elements at the invoice level give important information to enable easy recognition of these adjustments. These 3 data elements are only populated when the invoice being adjusted is a BWC Recovery adjustment:

- **Bill Recovery Adjustment Type Code (CAS05)** – Indicator of a special BWC payment due to a medical recovery. This value will be a “9”.
- **Bill Recovery Adjustment Total Amount (CAS06)** – The total amount of the special BWC recovery payment line items.
- **Bill Recovery Adjustment Number of Line Items (CAS07)** – The count of the number of line items that are BWC Recovery payments.

Regular Line Adjustments have two iterations of the adjusted line on the 835. BWC Recovery Adjustments contain a *third* iteration of the line, called the “Recovery Payment Line Item”. This is the line item that contains the BWC recovery payment amount that is issued to the MCO to offset the negative impact when the “reversal line” and “new benefit line” are added together. The “Recovery Payment Line Item” amount (in the SVC02) will offset the negative impact resulting in a “zero” effect on the EFT total. The Line Item Adjustment Type Code (CAS02) is equal to a “9”, meaning “Recovery Adjustment Line”.

c. EOBs

In addition to the 835 changes, BWC will also include specific EOBs to give business staff more information about the various parts of the BWC Recovery Adjustments.

All line items will contain:

888 – BWC Recovery Adjustment. This will be attached to all lines (Reversal, New Benefit, & Recovery Payment).

Reversed line items will contain an EOB explaining the reason the funds were collected. Two examples are below. As other situations arise, BWC may add new EOBs to use in this process.

890 – Item reversed following Self Insured Department recovery. This EOB will be used if the adjustment is due to a situation where a claim came into BWC assigned a state fund claim, then later determined to be the responsibility of the active Self-Insured employer. A BWC Recovery Adjustment will be initiated when these medical dollars are collected by BWC.

875 – Item reversed following BWC Fraud Investigation recovery. This EOB will be used if the adjustment is due to a situation where the BWC Special Investigation Unit collected overpaid medical dollars directly from a provider following an investigation.

The Recovery Payment Line Item will contain an EOB to specifically identify this part of the BWC Recovery Adjustment. This is the line item that is the payment to the MCO that offsets the combined negative effect of the reversed and new benefit line items. In other words, this is the amount that was recovered from the provider for the previously paid line item.

899 – Item adjusted - BWC Recovery amount

MCOs should e-mail any questions regarding this process to:
medicalbillpaymentrecovery@bwc.state.oh.us.

17. Overpayment Recovery Policy

In accordance with Section 4121.32(D) of the Ohio Revised Code and applicable sections of the Ohio Administrative Code, BWC established the following Provider Overpayment Recovery Policy effective September 1, 2009 to govern the actions of BWC, Managed Care Organizations (MCOs) and medical providers regarding the recovery of provider payments made in error.

I. Policy

- A. The recovery of provider payment from providers shall be initiated where payment was made to providers in conflict of law, rule, BWC provider agreement or policy.
- B. Provider overpayment recovery and MCO overpayment recovery is subject to a time limitation as follows:

The provider or MCO must be notified of the overpayment within two (2) years of the BWC bill system process date. If the provider or MCO is not notified of the recovery demand within such two (2) year time period, no recovery shall be ordered. This two (2)

year limitation does not apply to payments where the provider or MCO was aware of the overpayment or became aware within two (2) years of receipt of payment.

- C. The provider may request review of the recovery decision by the MCO pursuant to the Bill Grievance process. Subsequent review may be requested of BWC Medical Services Division Chief's designee and, upon request, final review by the Administrator's designee.
- D. Provider payments made as a result of MCO or BWC error and where the provider rendered services and sought reimbursement in good faith shall not be recovered from the provider. BWC shall initiate recovery from the MCO of any overpayment made as a result of MCO error unless overpayment is recovered from the provider. An MCO payment error exists when payment is made to a provider which is inconsistent with current health care provider payment standards and industry practices or in conflict with law, rule, or the MCO contract. The MCO may request review of the recovery decision by BWC Medical Services Division Chief's designee and, upon request, final review by the Administrator's designee.

II. Procedure

- A. The MCO is not responsible for re-payment, and shall not recover from the provider, overpayments resulting from the disallowance of a previously allowed claim or condition. If the MCO authorizes services in error, the MCO shall inform the provider immediately by phone and in writing that service was authorized in error and that the provider will not be paid for any service rendered after the date of notification. The MCO may not withdraw authorization for services that were already authorized and rendered. The MCO shall be responsible for payment of all service rendered prior to and on the day of the notification.

MCOs shall initiate recovery of overpayments only after all appeal periods have been exhausted. All paper correspondence shall be mailed to the provider's correspondence address.

- B. If a party to the claim files an appeal for services through the ADR process or with the Industrial Commission regarding treatment which has already been rendered, the MCO shall take the following steps:
 - 1. Within two (2) business days of learning of the appeal, the MCO shall inform the provider by phone and in writing that services are now under appeal and may be subject to non-payment.
 - 2. Bills for service that have already been paid in compliance with Ohio BWC laws and rules shall remain paid. Bills for service that have not been paid shall be pended until appeals through the IC SHO level are exhausted.
 - 3. If the final decision from the ADR process or the Industrial Commission allows provider reimbursement for the treatment, bills shall be paid. If the final decision denies the provider reimbursement and the overpayment was due to MCO error, the MCO shall be responsible for reimbursement to the provider or BWC from the MCO administrative account for services authorized and rendered on or before the date the

MCO notified the provider of the pending appeal. If no MCO error occurred, pended bills will be denied.

C. Discovery of an Overpayment and Initial Notification

1. Within fourteen (14) calendar days of discovery and verification of provider overpayment, the MCO shall send written notice to the provider informing the provider of the overpayment and the requirement for provider repayment. The notice shall contain a complete and specific rationale for the repayment, including identification of the specific documents supporting the rationale. The notice must include instructions regarding the provider grievance conference process and the forty-five (45) calendar day time period for provider objection.
2. Within fourteen (14) calendar days of the date of original MCO overpayment notification to the provider, the MCO shall contact provider by means other than letter to verify the notification letter was received and discuss whether the provider disputes overpayment.
3. If the MCO's attempts to contact the provider are unsuccessful, an overpayment notification letter shall be sent via certified mail. If the certified letter is returned to the MCO, the MCO shall attempt to contact the provider during the next fourteen (14) calendar days to continue recovery efforts.
4. In the event the provider has ceased operations, the MCO recovery effort will stop and recovery will be referred to Medical Billing and Adjustments-Recovery (MB&A Recovery) via email at MedicalBillPaymentRecovery@bwc.state.oh.us.

D. Provider agrees with the initial overpayment notification from the MCO

1. If the provider agrees with the MCO determination of provider overpayment, the MCO and provider shall further agree on the method and time period for repayment (e.g. provider submitting check or MCO taking payment from future reimbursement). In no case, shall the time period for repayment extend beyond forty-five (45) calendar days from the date of the agreement.

After the overpayment is collected, the MCO shall send the request for adjustment with supporting documentation to MB&A via email at HPP.Adjustments@bwc.state.oh.us or fax to 614 621-3135 within fourteen (14) calendar days. Each state holiday falling within the fourteen (14) calendar day period shall extend the deadline by one (1) calendar day.

2. If payment of requested recovery amount is not received within forty-five (45) calendar days of date of initial agreement, MCO shall contact and send a follow-up letter to provider restating the terms of repayment.

E. Before a bill adjustment is submitted to BWC by the MCO, the overpayment must be recovered by the MCO and deposited into the MCO's provider account.

F. Recovery from Provider's future payments

The MCO may recover provider overpayment from provider's future payments. If recovery of funds is designated from such future payments, the repayment can be taken from any provider location operating under the same Tax ID number as the original

provider. The MCO shall inform the provider in writing that recovery will offset future payments due to overpayment and must provide the set-off amount and reference all prior MCO recovery efforts in this case. A list of all the provider locations from which the recovered amount will be deducted shall be specified in this notice. The MCO must identify the amounts recovered on the provider remit when the overpayment is recovered from future payments.

After the overpayment is collected, the MCO shall send the request for adjustment with supporting documentation to MB&A via email at HPP.Adjustments@bwc.state.oh.us or fax to 614 621-3135 within fourteen (14) calendar days. Each state holiday falling within the fourteen (14) calendar day period shall extend the deadline by one (1) calendar day.

G. No response from provider to MCO request for overpayment recovery

1. If provider does not respond to the MCO's request for recovery within ninety (90) calendar days of date of notification letter sent via certified mail, or subsequent follow-up letter as referenced in section D.2, MCO shall notify MB&A Recovery and submit supporting documentation via e-mail, and track and document the information accordingly (see section I of this procedure). The information must include the following:
 - a. Copy of original overpayment recovery request
 - b. Copy of 2nd overpayment recovery request sent via certified mail
 - c. Copy of certified mail receipt or verification of delivery
 - d. Documentation of all recovery efforts
2. Documentation review by MB&A Recovery
 - a. *Upon receipt of complete overpayment information, MB&A Recovery will research, review, and determine the appropriateness of recovery. If the MCO information is incomplete, MB&A Recovery will notify the MCO. The MCO must provide the complete information within seven (7) calendar days of notification.*
 - b. *If BWC determines that recovery shall not be made, MB&A Recovery will notify MCO. The MCO must then notify the provider of the decision.*
 - c. *If MB&A Recovery determines that recovery shall be made, MB&A Recovery will send provider a demand for recovery. The demand letter shall provide notification that the provider has forty-five (45) calendar days from date of letter to either reimburse BWC for the overpayment or dispute overpayment determination. The letter will also include details supporting the overpayment determination, instructions for submitting payment to BWC, consequences for non-payment, and provider appeal remedies.*

H. Provider Disputes MCO Overpayment Determination

1. If the provider does not agree with the MCO overpayment determination, the provider may dispute the decision. Provider notification of appeal must be made to the MCO within forty-five (45) calendar days from the date of receipt of the MCO notification of overpayment. Provider appeal must be in writing. If the provider does not appeal the MCO's determination, the MCO shall notify MB&A Recovery as detailed in section G.

2. If the provider timely appeals the MCO's determination, the MCO shall schedule a grievance conference in accordance with the "MCO's Grievance Hearings with Providers Policy" as set forth in the MCO Policy Reference Guide (MCOPRG).
3. Upon conclusion of the grievance conference, the MCO shall issue a written decision to the provider within seven (7) calendar days. The letter shall contain at least the following:
 - a. The date, time, place and participants in the conference,
 - b. The MCO's rationale for the decision,
 - c. Address for submitting reimbursement to MCO,
 - d. Notification that the provider may appeal the MCO's grievance conference decision to BWC management within forty-five (45) calendar days of the date of the grievance conference decision letter by sending their dispute in writing to:

E-mail box: medicalbillpaymentrecovery@bwc.state.oh.us or

Fax: (614) 621-1059 or

Mail: MB&A Recovery

30 W. Spring St. L20

Columbus, OH 43215

- e. If the provider does not appeal the grievance conference decision within forty-five (45) calendar days, the MCO shall notify MB&A Recovery as detailed in section G.
4. If the provider disputes the MCO's Grievance Conference decision and submits a timely appeal to MB&A Recovery, the recovery dispute will be staffed by the MB&A Manager and the Medical Services Division Chief's designee. They shall determine whether recovery is appropriate and issue their written decision to the provider within forty-five (45) calendar days of receipt of the appeal. The provider will be notified of the opportunity to appeal their decision to the Administrator's designee within forty-five (45) calendar days of the date of the notification of the decision through the any of the methods identified in section H.3.c.
5. If the provider appeals the BWC management decision:

The Administrator's designee will review and make the final determination and notify the provider of the final decision within forty-five (45) calendar days of receipt of the appeal. The notification shall be sent to provider via certified mail with copies sent electronically to the MCO.

I. Tracking and Documentation:

1. Due to the potential of recovery for multiple claims for the same provider, provider recovery information shall not be imaged into the IW's claim nor notes be placed into the IW's claim record. MCOs shall maintain a distinct and separate file for each overpayment recovery case. The file shall contain all relevant documents and communications. Upon request by BWC, the MCO shall provide a copy of the requested recovery file to BWC within seven (7) calendar days.
2. MCOs shall identify and track the status of recovery adjustments.

3. MB&A Recovery will track all recovery actions through to resolution.

J. Recovery of overpayments due to MCO error:

1. Upon BWC verification of an MCO error in treatment authorization or bill payment, MB&A Recovery shall notify the MCO via e-mail.
2. If the MCO agrees with the determination by MB&A Recovery, the MCO shall make payment from the MCO's administrative account to either the provider or to BWC, as directed by BWC, within fourteen (14) calendar days of the BWC notification.
3. If the MCO does not agree with the determination by MB&A Recovery, the MCO may dispute the determination by responding to the e-mail from MB&A Recovery within fourteen (14) calendar days of receipt.
4. The dispute will be considered by MB&A Recovery and staffed with other BWC subject matter experts as needed.
5. The Medical Services Division Chief's designee (designee) shall review the MCO appeal and notify the MCO of the decision via email within forty-five (45) calendar days of receipt of the appeal.
6. If the MCO agrees with the decision by the designee, the MCO shall make payment from the MCO's administrative account to either the provider or to BWC, as directed by BWC, within fourteen (14) calendar days of the designee notification.
7. If the MCO does not agree with the decision by the designee, the MCO may appeal the decision to Administrator's Designee by responding within fourteen (14) calendar days by email at medicalbillpaymentrecovery@bwc.state.oh.us. The Administrator's Designee shall review the appeal, and inform the MCO of the decision within fourteen (14) calendar days of receipt of the appeal via email, and copy the Director, Compliance/Performance Monitoring and the Director, MCO Business & Reporting. MCO must submit documentation supporting completion to BWC Compliance/Performance Monitoring.

a. Billing Grievance Policy

In accordance with Rule 4123-6-044(B), the MCO shall have in place and operating a grievance hearing procedure allowing a provider, employer, or employee to grieve a disputed bill payment.”

The BWC rule uses the term “grievance hearings” or “grievance conference” to describe the appeal procedure the MCO must have in place. The MCO's grievance hearing procedures are limited to 1) appeals regarding the recovery of overpayments and 2) bill payment disputes such as denial of payment or reduced payment.

Grievance hearings shall not address fee schedule grievances or ADR issues. The grievance hearing gives the disputing party the opportunity to present evidence to support the disagreement and affords due process.

1) Recovery of an Overpayment

MCOs implemented a recovery grievance conference that provided due process for the provider and adjudicated disputes regarding recovery of reimbursements in the following manner:

- Provider is notified by MCO an overpayment has been identified and adjustment will be processed to recover the funds.
- The provider may appeal the MCO's decision in writing within 45 calendar days.
- The MCO's recovery grievance conference will allow a provider to grieve the disputed bill payment. The MCO will schedule a recovery grievance conference within 14 days upon receipt of the provider's written appeal. The MCO must notify the provider of the date, time, and location of the conference, the issue and a statement of fact. The conference will be limited to the stated issue in the letter.
- Upon conclusion of the recovery grievance conference, the MCO will issue a decision, in writing, to the provider within 7 calendar days.
- The provider may appeal the MCO's recovery grievance conference decision to BWC's Administrator's designee. The provider may appeal the MCO's recovery grievance conference decision to BWC Medical Bill Payment Recovery, within 14 days after receiving the decision of the MCO, via email to: medicalbillpaymentrecovery@bwc.state.oh.us
- The Administrator's designee will review and make the final determination within 14 days.

If an MCO determines an overpayment should be recovered because the service did not meet Miller criteria (medically necessary and appropriate, related to the treatment of the industrial injury and the costs medically reasonable), then the MCO may initiate recovery. However, if the provider appeals that recovery, then the recovery process shall stop and the appeal submitted by the provider should be considered as an ADR appeal. The receipt date of the provider's appeal by the MCO will be day one of the ADR process. The MCO must follow the criteria for appeals received in ADR, for example, the appeal must be signed.

2) Medical Billing Dispute

A medical billing dispute exists when a provider is not satisfied with the amount of payment and explanation of benefits received from an MCO, but does not include dispute of BWC's fee schedule rates. NOTE: If the payment denial is because the service did not meet *Miller* criteria (**Rules 4123-6-16.2(B)(1) through (B)(3)**), then the issue should follow the ADR appeals process, not the medical billing dispute process. The provider should submit a request for reconsideration to the MCO to begin the bill grievance dispute. The MCO shall review the bill, and determine if the provider is correct and an adjustment is appropriate or if the MCO's initial payment was correct. If the MCO's review determines that the issue is still not resolved, they should proceed to the bill grievance conference process. The MCO must provide the reason and the rationale for the initial medical bill payment decision. Examples of the rationale may include BWC's coverage provisions or coding conventions. The MCO's procedure may be a review by a nurse or supervisor. Once the review is completed, the decision on the review is communicated to the provider in writing.

a) Procedures for Handling Billing Disputes

When a provider disagrees with the denial of payment or a reduced payment a medical billing dispute exists and the following steps shall be taken:

- The Provider contacts the MCO to inquire about the reimbursed amount or denial of a medical bill via; e-mail, fax, phone, mail. It may be necessary to submit the inquiry, along with supporting documentation, in writing to the MCO. The provider and the MCO should keep detailed notes for his/her records, including the name and phone number of the person to whom he/she spoke, fax confirmations, etc.
 - It may be necessary for the provider to request to speak to an MCO supervisor to resolve the issue or to escalate the issue to a grievance conference. Most provider billing inquiries can be handled by the MCO on the phone.
 - The MCO shall acknowledge the inquiry (e-mail, fax, phone, mail) within four (4) calendar days of receipt, and shall resolve or initiate resolution of the inquiry within seven (7) calendar days of receipt per the MCO contract.
 - If the issue is not resolved with the MCO, the provider should be instructed on how to initiate a medical bill grievance conference with the MCO. The conference may occur in person or via telephone, and shall occur within seven (7) calendar days from the request for the conference. MCO's must document details of all grievances conferences and the outcome.
 - The MCO shall issue a decision, in writing, within seven (7) calendar days from the date of the conference. The MCO's determination letter shall be imaged into the injured workers claim. Imaging documents in the claim will make it possible for BWC to research any subsequent provider complaint that may come into the Provider Contact Center and will provide documentation that the medical bill grievance was addressed.
- 6th) Required Elements for "Bill Dispute Grievance Conference Decision." letter.
- i. Identification of the specific documentation reviewed at the conference such as the office notes or other documentation;
 - ii. Date, time, place and persons who participated in the conference (MCO and Provider) and the method used for the conference (phone, face to face or email).
- 7th) If the provider does not agree with the MCO's decision, the provider may contact BWC's Provider Contact Center at 1-800-OHIOBWC, option 0-3-0 or via email at feedback.medical@bwc.state.oh.us to ask for BWC's assistance in resolving the billing dispute. It is the MCO's responsibility to inform and provide this information to the provider. The BWC Provider Contact Center will ask the provider to document the complaint, which will be researched and tracked. It may be necessary for the BWC Provider Contact Center to consult other BWC departments such as, (but not limited to) Medical Policy, Voc Rehab

Policy, Medical Director or Legal or for input in making a determination.

- 8th) BWC's provider contact center will refer the provider back to the MCO if the grievance conference has not been held. If the MCO did not conduct a medical bill grievance conference or the documentation has not been imaged into the claim, the provider's request for a medical bill dispute shall be referred by BWC back to the MCO. BWC will educate the provider on the process and the steps that are established to handle such inquires/requests/grievances.
- 9th) BWC's Provider Contact Center will coordinate a written response to the provider and the MCO and send the response to the IW's claim file. After BWC's determination is rendered, no additional levels of review will be considered.
- 10th) If at any point during the inquiry/dispute process the MCO or BWC determines that a payment correction is needed, the MCO shall correct or submit an adjustment to BWC within fourteen (14) calendar days of determination. If BWC has reviewed and made a determination to instruct the MCO to pay the provider, the MCO will notify the Provider Contact Center when the payment is released. .

Payment Error to a party other than the authorized "pay-to" provider:

Policy:

If, due to MCO error, the MCO has made payment in error to a party other than the authorized "pay-to" provider on a bill, the MCO shall, at the MCO's expense and not out of the MCO's dedicated provider account, deposit the incorrectly paid amount into the MCO's dedicated provider account and reimburse the correct "pay-to" provider within seven (7) days of notification by the authorized "pay-to" provider or the Bureau or within seven (7) days of the adjustment being processed.

Procedures:

Funding the Provider Account

Following confirmation of the MCO payment error, the MCO shall initiate the banking transaction to deposit the determined amount into the MCO provider account from the MCOs operating account. Supporting documentation for this deposit shall be maintained by the MCO for validation by BWC and will include (at a minimum):

- 1) Dated documentation identifying the error (i.e.: system note recapping phone conversation, e-mail, fax, mail received the postal system and/or MCO internal QA documentation);
- 2) The bank instrument of deposit (i.e.: wire transfer authorization document, cancelled check from operating account);
- 3) The bank deposit slip for the provider account; and
- 4) Cancelled check issued to the authorized "pay-to" provider written on the provider bank account.

Adjustment Required

If an adjustment request is necessary prior to issuing the payment to the authorized "pay-to" provider, the following supporting documentation will also be required:

- 1) Adjustment packet submitted to BWC; and
- 2) EDI 835 reconciliation reports.

Reimbursing operating account for recovery of payment error

If the MCO eventually recovers the payment from the provider paid in error, the MCO may reimburse their operating account for the exact amount of payment returned which does not exceed the amount deposited from the MCOs operating account. Prior approval must be obtained from **BWC Compliance and Monitoring Department** prior to reimbursing the MCOs operating account on amounts exceeding \$500.00. Supporting documentation required to obtain BWC approval includes:

- 1) Copy of provider issued check;
- 2) Deposit slip validating deposit of the provider issued check into the provider account, including itemized list of checks included in the total deposit; and
- 3) Documentation noted above under “Funding the Provider Account”.

After reimbursing the MCOs operating account, the following supporting documentation shall be maintained by the MCO for validation by BWC and will include (at a minimum):

- 1) Bank instrument of deposit into operating account (i.e.: wire transfer authorization document, cancelled check from provider account); and
- 2) The bank deposit slip for the operating account.
- 3) Line item in provider account reconciliation of total funded and withdrawal amount

18. Provider Account Zero Balance Reconciliation

The MCOs are required to maintain a zero balance reconciliation of their provider account. A zero balance reconciliation ensures that every penny deposited into the provider account is accounted for in either a) a payment to a provider, b) an adjustment back to BWC, or c) a reimbursement to an MCO for monies they issued a provider from their operating account. For the zero balance reconciliation, BWC has developed a spreadsheet that should be completed monthly and submitted to BWC quarterly, no later than the 2nd month following the end of calendar quarter with the routine monthly provider account reconciliation submissions. The spreadsheet has categories (buckets) identified to be used in grouping similar transactions and can be completed by using the provider account monthly bank statement, reconciliation documents, and adjustment and void logs. The MCO must categorize transactions into one of the following categories at a minimum, although more may be added by an MCO:

1. Total deposits/credits to MCO provider account
 - a. Re-issued payments
 - b. Refund to BWC - Adjustments
2. Total void/stop pay checks
 - a. Re-issued payments
 - b. Refund to BWC – Adjustments
3. Total amount held from future provider payments
4. Total amount of unresolved BWC initiated overpaid adjustments

At times, an overage or shortage may exist that cannot be identified to a specific transaction(s). This difference may be identifiable in a later reconciliation, but not always. After a difference has been identified for more than 3 consecutive months on the monthly zero balance reconciliations, BWC will require that the MCO resolve the difference by bringing the account balance to a zero. The MCO is to notify CPM that this has occurred and BWC will provide instructions to the MCO on resolving any identified differences.

“Zero balance reconciliation” definition: transactions recorded in the sub-ledgers within the general ledger when accounted for appropriately, at any given time, will always balance to zero. Balancing accounting books means to add up all accounts and make sure they result in a zero. When the accounts do not sum to zero, the accountant must look for entry errors. Common errors include recording the wrong amount on one of the double entries, reversing debits and credits on entries or transposing figures, etc. When all accounts balance to zero, you know entries were placed in their proper position and there was an accurate accounting for the relevant transactions.

B. PAYMENT RULES

The MCO shall pay provider bills in accordance with Rules 4123-6-08, 4123-6-10, 4123-6-37.1, 4123-6-37.2, 4123-6-37.3, and 4123-18-09 of the Ohio Administrative Code. If the MCO has elected to retain a provider panel or has entered into an arrangement with providers, the MCO’s contracts with providers shall describe the method of payment to the providers. The MCO shall provide an MCO panel provider fee schedule to each provider that contracts with the MCO. The MCO panel provider fee schedule may be at different rates than BWC’s fee schedule. The MCO shall make the MCO panel provider fee schedule available to the bureau as part of its application for certification. BWC shall maintain the MCO panel provider fee schedule as proprietary information

1) Amount Reimbursed

MCOs are strictly forbidden from retaining any portion of the amount paid by BWC for provider services. The arrangement of paying the MCO for provider services is seen as a flow through and the MCO should retain no portion. It is important to note that the total RVU adjustor for each CPT code in BWC’s payment system is carried out to five decimal places. In rare instances, BWC’s maximum allowable rate may differ slightly from the amount listed in its fee schedule publications because BWC rounds the final product to two decimal places. This applies most frequently in cases where multiple units are billed.

2) Copayment or Deductible

In HPP, injured workers are not required to contribute a copayment and do not have to meet any deductibles. For this reason, BWC-certified providers are forbidden from billing the injured worker for reimbursable covered services.

3) Balance Billing

In accordance with R.C. 4121.44(O), health care providers must accept the reimbursement from the MCO as payment in full. Providers may bill neither the injured worker nor the employer for any difference between the provider’s charge and the amount allowed by the MCO. When a provider provides services for an allowed condition that are not covered under the workers’ compensation program, the provider must notify the injured worker prior to delivering services that the service is not covered by the MCO. The provider also must inform the injured worker that he or she will be responsible for payment. The injured worker must agree to the provision of the services and understand that the services are not payable by workers’ compensation prior to the service being rendered. This, however, does not enable providers to balance bill an injured worker for the difference between the BWC paid amount and the provider’s billed amount for a BWC covered service.

4) Injured Worker Reimbursement

a. Health Care Services

MCOs are responsible for processing requests for injured workers seeking reimbursement for health-care services for which they paid or another party paid on their behalf. The provider that provided the service must be enrolled with BWC and must identify the necessary billing data elements, such as codes and dates of service. The MCO must determine through examining proof of payment, such as a canceled check submitted by the injured worker, that reimbursement is appropriate.

b. Claimant Travel Reimbursement Guidelines – see policy in Chapter 9

5) Travel Reimbursement Rates -refer C-60A on www.ohiobwc.com

6) Usual, Customary and Reasonable (UCR) Fee or Charge

Providers must bill their usual charges for services reported based on CPT and medical documentation (the same charges billed the public). Providers will be monitored to assure that billed charges are their usual charges. For coded services that do not have an assigned fee, the MCO shall conduct research to determine the usual, customary and reasonable amount to be reimbursed for both panel and non-panel services. MCOs can also refer to the current professional provider fee schedule preamble for further direction regarding \$0.00 CPT codes.

The MCO shall not authorize payment for services or supplies provided by a BWC non-certified provider if the services or supplies are available through a BWC certified provider. The MCO shall research the availability of a BWC certified provider.

7) Provider Payment Not Received by Provider

The MCO shall issue a new check to the provider within 7 business days following notification from the provider that payment has not been received within 30 calendar days from the MCO check issuance date. The MCO may issue a stop payment on the original check or assume responsibility for recovery of the overpayment in the event that duplicate payment is made to the provider.

8) Modifying Provider Fee Bills

The MCO shall document all changes made by the MCO to the original provider fee bill and report the change to BWC electronically by means of the appropriate EOB code as well as to provide EOB to the submitting provider. Should the MCO choose to facilitate bill payment by correcting or modifying a provider's bill, the MCO should not delete the inappropriate procedure from the bill but should remove the provider's charge from that line and add a new line with the charges and the replacement procedure code; both lines should contain appropriate EOB.

9) Medicare Requests for Reimbursement

Inquiries from Medicare (CMS) and its agents requesting reimbursement from BWC for medical bills paid for injured workers with allowed Ohio Workers' Compensation claims are to be handled by BWC's Medical Billing and Adjustments (MB&A) department. Until

requested to do otherwise, please mail all Medicare requests for payment, within seven (7) days of the MCO's receipt of the request, to: Ohio BWC, 30 West Spring Street, L-22, Columbus, Ohio 43215. Documents may also be emailed to shannon.b.1@bwc.state.oh.us.

10) Provider Reimbursement in Multiple Claims Policy

The purpose of this policy is to provide a method of appropriate reimbursement to medical providers who treat injured workers with multiple claims on the same date of service. BWC's Billing and Reimbursement Manual states that a provider may be reimbursed for only one Evaluation and Management service per day, regardless of the number of claims being treated. The code is to be billed to the claim representing the chief complaint or reason for the visit. Other services may be billed in multiple claims as described below.

Billing all treatment in one claim rather than dividing it between two or more claims could be perceived as fraudulent billing.

a. Policy/Procedures

A provider may be reimbursed for only one Evaluation and Management service per injured worker per day. Exceptions must be reviewed on a case by case basis. (Example: E/M service was provided in the morning, but due to an unforeseen problem, the injured worker had to return later in the day for a reason that would require another complete E/M service.)

If a provider is treating an injured worker with multiple claims, Evaluation and Management services may be billed in one claim only for each visit. The service should be billed to the claim representing the chief complaint or reason for the visit.

If multiple physicians provide Evaluation and Management services to an injured worker on a single day for conditions allowed in a claim, upon review of documentation, an MCO should reimburse each provider for the E/M service.

b. Osteopathic manipulative treatment

Additional reimbursement will not be made to cover administrative costs for billing in more than one claim. Treatment will not be routinely reimbursed in more than two claims. Effective Sept. 1, 2004:

- If one body region is allowed in each of two claims, each claim may be billed with CPT® 98925. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.
- If a total of **three or four body regions** are allowed and treated in two claims, two in one claim and one or two in a second claim, each claim may be billed with 98926. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.
- If a total of **five or six body regions** are allowed and treated in two claims, each claim may be billed with 98927. For the primary or most significant claim,

modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.

Reimbursement for osteopathic manipulative treatment provided in two claims will be 50% of the BWC fee for each claim. Failure to use the modifiers in both claims will cause the second bill submitted to be denied as a duplicate.

Osteopathic manipulative treatment billed in more than two claims on the same date of service will be denied.

c. **Chiropractic manipulative treatment**

Additional reimbursement will not be made to cover administrative costs for billing in more than one claim. Treatment will not be routinely reimbursed in more than two claims. Effective Sept. 1, 2004:

- If one spinal region is allowed in each of two claims, each claim may be billed with CPT® 98940. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.
- If a total of **three or four spinal regions** are allowed and treated in two claims, two in one claim and one or two in a second claim, each claim may be billed with 98941. For the primary or most significant claim, **modifier PC** must be added to the code. **Modifier SC** must be added to the code in the second claim.
- If a total of **five spinal regions** are allowed and treated in two claims, each claim may be billed with 98942. For the primary or most significant claim, **modifier PC** must be added to the code. The second claim must be billed with 98942 with modifier **SC** added to the code.
- If at least one extraspinal region is allowed in each of two claims, each claim may be billed with CPT® 98943. For the primary or most significant claim, modifier **PC** must be added to the code. Modifier **SC** must be added to the code in the second claim.

Reimbursement for chiropractic manipulative treatment provided in two claims will be 50% of the BWC fee for each claim. Failure to use the modifiers in both claims will cause the second bill submitted to be denied as a duplicate.

Chiropractic manipulative treatment billed in more than two claims on the same date of service will be denied.

d. **Physical medicine procedures**

Effective Sept. 1, 2004:

- CPT® codes 97012 – 97028 are reimbursable in only one claim per date of service as these codes describe treatments to **one or more areas** without time specifications

- CPT® codes 97032 - 97530 may be reimbursed in only one claim if a total of fifteen minutes or less are provided
- CPT® codes 97032 – 97530 may be reimbursed in more than one claim if the total time units for each service exceed one unit or fifteen minutes. For each fifteen minutes, one unit may be billed in each claim using modifier **PT** in the first claim and **ST** in the second claim. For example, CPT® code 97110 – therapeutic exercises to develop strength and endurance are done for 30 minutes. If the injured worker has two claims, one unit can be billed in each.
- Reimbursement for physical medicine procedures will be at the lesser of the provider charge, BWC’s maximum allowable rate or the MCO's negotiated rate for panel providers.

11) Eye Examination and Eyeglass/Contact Replacement Policy

The purpose of this policy is to clarify issues related to:

- the reimbursement of refraction (eye exam) for new eyeglasses or contact lenses due to damage or loss of the injured worker’s eyeglasses or contact lenses as a result of an industrial injury.
- the replacement of new eyeglasses or contact lenses for ones that were damaged during or as a result of an industrial injury.

BWC Customer Service Teams (CSTs) and the MCOs receive inquiries from IWs and providers regarding reimbursement of an eye exam prior to the dispensing of new eye glasses/contact lenses in situations where an injured worker damages or loses eyeglasses or contact lenses in the course of a work related injury. Requests include questions regarding reimbursement of refraction in situations where the broken glasses were “old,” or the injured worker has not had a recent eye exam. In addition, issues arise regarding reimbursement for the replacement eye glasses/contacts including payment for special features such as “deluxe frames” plastic lenses, anti-reflective or scratch resistant coatings. These features will only be reimbursed with documentation from the servicing provider demonstrating that a deluxe feature was damaged in the work related incident.

34Rule 4123-6-31(D) which addresses payment for eyeglasses and contact lenses, limits the reimbursement of the eye exam to a specific situation as noted below:

- (D)(2) Contact lenses or glasses are reimbursed when loss of vision is the direct result of a physical injury or occupational disease.
- (D)(3) Refractions will be approved in situations outlined in paragraph (D)(2) of this rule.

The MCOs will continue to follow this rule when making decisions regarding reimbursement of eye exams. This approach is also supported by the *Miller* criteria (Rules 4123-6-16.2(B)(1) through (B)(3)). It is the responsibility of the injured worker to obtain and pay for an eye exam if the exam is required to replace the glasses/contacts unless the loss of vision is the direct result of a physical injury or occupational disease as defined by BWC rule. The IW also has the option of obtaining a copy of the most recent prescription for the broken eyeglasses/contact lenses from his/her optometrist/ophthalmologist and using this prescription to replace the glasses/contacts, if the prescription is considered valid by the prescribing provider.

In a situation where the injured worker's eyeglasses were damaged during or as a result of the industrial injury and BWC is reimbursing new eyeglasses/contact lenses, Rule 4123-6-31(D) says: states that BWC will "replace" the eyeglasses/contact lenses. In order for BWC to reimburse the replacement eyeglasses or contact lenses, evidence is needed to document the specific features of the broken glasses/lenses so that BWC can reimburse these items according to the current BWC fee schedule. It is the responsibility of the IW to obtain a copy of the bill or itemized statement from the supplier of the original glasses/contacts or to take the broken glasses to an optometrist so that the optometrist can itemize the features of the glasses. This will provide the information that BWC needs to correctly reimburse the replacement glasses/contact lenses.

Per 34-Rule 4123-6-31(D), glasses or contact lenses will be approved for treatment purposes, when necessary, as a direct result of the allowed injury or occupational disease. Any subsequent adjustment, maintenance supplies or change in a claimant's glasses or contact lenses, if required for treatment of the allowed injury or occupational disease, will also be approved, when supported by evidence of a direct causal relationship. When eyeglasses and/or contact lenses were damaged or broken in an industrial accident and have been replaced, no further replacement will be approved due to subsequent breakage or for any other reason except as provided in this paragraph of this rule.

12) Unsupervised Physical Reconditioning Programs

BWC/MCOs shall not approve reimbursement for an unsupervised physical reconditioning program, such as services that are provided at a health club, YMCA, spa or nautilus facility, or home exercise equipment unless it is approved per the specific guidelines when an injured worker is participating in a vocational rehabilitation or remain at work program.

13) Physical, Occupational and Speech Therapy

The purpose of this policy is to clarify issues related to:

- Multiple therapy Price Reduction
- Coding clarification for billing of timed therapy units

Effective January 1, 2012, BWC is adopting a multiple therapy price reduction. The first unit of the primary therapy (determined by the highest relative value unit) will be reimbursed at 100% of the CPT© code fee schedule. Any subsequent units of therapy (the same or different) performed by the same provider on the same date of service are subject to a 25% reduction of the practice expense portion **only** of the RVU.

A timed therapy unit is 15 minutes in length, but accommodations have been made in the Medical Documentation Guidelines Appendix D reference table for reimbursement of partial units when the documentation policy has been correctly observed. The overage from a therapy unit(s) may be added to another timed therapy to calculate the total billable therapy time.

It is incorrect to add any combination of minutes of multiple therapies, such as 2 minutes of therapeutic exercise (97110), 2 minutes of manual therapy (97140), 2 minutes of gait training (97116) and 2 minutes of therapeutic activity (97530), merely in order to reach a threshold of

8 minutes and bill for a unit of therapy. Neither is it appropriate for therapy to be calculated in 2 four minute units to reach the 8 minute threshold. An example of such inappropriate billing and coding is 4 minutes of gait training (97116) and 4 minutes of therapeutic activity (97530). Additionally, combining any other multiple therapies minutes merely to obtain the 8 minute billing threshold is also incorrect coding. It is BWC policy that, in order for a therapy to be medically necessary as well as beneficial to the patient, it must be performed for a reasonable duration. It is also a requirement that the total number of timed minutes must be clearly documented in the patient medical record.

14) Prolonged Evaluation and Management services without Patient Contact

- These codes are not to be used when the provider is writing a letter of appeal for diagnosis allowance or treatment denial
- The service must relate to a visit where direct (face-to-face) patient care has occurred or will occur
- It must relate to ongoing patient management
- There must be clear medical record documentation of the time spent providing the non face-to-face service as well as the reason for service (i.e. medical record review for patient care)

15) Diagnostic Psychiatric Interviews

- Services described as diagnostic psychiatric interviews are performed during the initial phase of treatment only and the extent of the mental status examination depends on the patient's condition
- The goal of the examination is to establish a diagnosis (or non-diagnosis if there is no disorder) and evaluation protocol for the patient
- There are certain symptoms of psychopathology that the provider will study to determine the initial treatment plan such as, but not limited to, the patient's appearance, attitude, emotional state, and overall behavior

C. PROVIDER REIMBURSEMENT RATES

1. Provider Reimbursement Schedule

Aggregate professional fee levels have been established using 2010 relative value units (RVUs). There will continue to be a facility and non-facility fee for each CPT code.

Fee reimbursement levels for HCPCS Level II and Level III codes will reflect changes based on billed history review, comparisons with other payers, and recommendations from professional associations and stakeholders.

a. Hospital Inpatient Reimbursement

- 1) BWC currently reimburses hospital inpatient services using a modified version of Medicare's Inpatient Prospective Payment System (IPPS). The modifications adopted by BWC are specified in Ohio Administrative Code 4123-6-37.1. To view the current and previous hospital inpatient rules go to www.ohiobwc.com.

2) **Reimbursement of Readmissions**

All bills for repeat stays within a 30-day timeframe after discharge will be subject to review by a BWC medical reimbursement specialist. Readmissions to the same acute care IPPS hospital within 30 days may be combined with bills for previous admissions if the principal diagnosis is the same (or within the same ICD-9 grouping) as the prior confinement.

3) **Transfers between Hospitals**

When an injured worker is admitted to a hospital and is subsequently transferred to another hospital, the full prospective payment is made to the final discharging hospital. Payment to the transferring hospital is based upon a per diem rate. That per diem rate equals the prospective payment rate divided by the mean length of stay for the specific DRG into which the case falls. The per diem rate is paid at double the amount for the first day of stay. Subsequent confinement days at the transferring hospital are reimbursed at the calculated per diem rate, with the total amount not to exceed the DRG case rate. BWC will follow CMS/Medicare's post-acute care transfer policy for designated DRGs.

4) **Interim Bills**

BWC will not process interim bills (bill types 112 and 113) for interim stays of less than 30 days. For a length of stay of 30 days or greater, the initial interim bill submitted will be priced according to the applicable reimbursement methodology.

5)

Hospital Leave Of Absence

The MCO is responsible for authorizing a hospital leave of absence. BWC covers LOA from hospitals for catastrophic cases when the injured worker is admitted to learn new techniques and apply new strategies (involving daily activities) for his/her return home. The LOA from the hospital must be medically appropriate and express potential to be beneficial to the injured worker's recuperation. A reduced bed hold rate of 50% of the room and board rate will be reimbursed when an authorized LOA is billed using revenue center code 183.

6) **Inpatient hospital medical documentation**

The following documentation is typically needed in order to verify the bill data, including the diagnosis and procedure codes:

- √ Admission history and physical;
- √ Emergency department report - if patient was admitted through the ED;
- √ Operative report - if bill contains operating room charges and patient had surgery (Note: minor surgical procedures not performed in the OR are often documented in the progress notes);
- √ Discharge summary or physician progress notes- if admission was 48 hours or greater in duration;
- √ Discharge note - if admission was less than 48 hours in duration.

- 7) **Appeals** -All appeals regarding hospital reimbursement must be directed to the appropriate MCO.

When a hospital is appealing the amount of reimbursement for an inpatient hospitalization, it is the hospital's responsibility to submit the supporting medical documentation for review.

b. Hospital Outpatient Reimbursement

Effective for dates of service beginning 01/01/2011, BWC reimburses hospital outpatient services using a modified version of Medicare's Outpatient Prospective Payment System (OPPS). The modifications adopted by BWC are specified in Ohio Administrative Code 4123-6-37.2. To view the current and previous hospital outpatient rules go to www.ohiobwc.com.

c. Pharmacy *

*NOTE: BWC's PBM reimburses all outpatient medications. Refer to chapter 7 for more information.

d. Practitioner

Rule 4123-6-08 establishes a professional provider fee schedule. Relative Value Units (RVUs) have been assigned by the Centers for Medicare and Medicaid Services (CMS) for CPT® codes. BWC adjusts the total RVU by the Ohio Geographic Practice Cost Indices (GPCI) to determine BWC reimbursement. 2007 -2012 RVUs will be used to establish fees for newly created -2012 CPT codes in the 2012 BWC Professional Provider Medical Services Fee Schedule, effective January 1, 2012 via emergency rule OAC 4123-6-08. The 2011 RVUs were utilized for the remainder of the CPT codes.

The professional fee schedule will list a facility and non-facility fee for CPT codes as there may be two distinct fees for a CPT code. BWC's professional fee schedule can include a place of service difference in a Relative Value Unit which will impact the reimbursement.

Service Type	CPT Code Range	Conversion Factor
Anesthesia	00100 - 01999	42.50000 per 15 min unit or 2.83333 per minute
Surgery	10021 - 69990	-221% of Medicare fee schedule
Radiology	70010 - 79999	-142% of Medicare fee schedule
Pathology	80048 - 89399	125% of Medicare Fee

		Schedule *
Physical Medicine	97001 - 98943	-142% of Medicare fee schedule
General Medicine	90281 - 96999 99000 - 99600	-142% of Medicare fee schedule

* CPT Codes not assigned a RVU are reimbursed based on historical and other payer data.

NOTE: CPT code reimbursement may also be affected by the addition of a modifier. Please refer to the *Billing with Modifiers* section for further details.

e. Medical Goods/Services

BWC has developed fees for HCPCS Level II and III coded services, including ambulance, dental, medical supplies, DME, orthotics, prosthetics, vision, vocational rehabilitation, home health and nursing home based on historical and other payer data.

f. Guidelines for Using BWC’s Provider Fee Schedule

Upon execution of a CPT end user agreement with BWC for a given calendar year, the MCO may utilize downloadable versions available on the MCO Portal. Each individual at the MCO who accesses, uses, and/or manipulates CPT codes contained in that electronic product is required to review and sign an end user agreement.

In order to assist providers who are not familiar with BWC’s published Provider Fee Schedule, MCOs are reminded that BWC’s Provider Fee Schedule is available on the BWC’s website at **ohiobwc.com**. Providers may download a copy from the Provider Forms page or access the interactive version on the Fee Schedule lookup page.

The downloadable version lists both physician fees and ambulatory surgery center (ASC) fees for surgical CPT© codes 10021-69990. If the fee is listed on the professional fee schedule as \$0.00, the code is not covered and will not be reimbursed.

The interactive version can be used to find fees associated with codes for practitioners, supplies and services. The fee schedule look-up does not include the ASC payments. The only codes that are affected by inserting a modifier along with the CPT code are the radiology and other CPT codes that may have a corresponding - 26 (professional component) or TC (technical component) associated with them. Modifiers cannot be used with other CPT codes when using the fee schedule look-up.

g. Guidelines for Payments for By Report codes, and Negotiated Reimbursement Rates

1) Payments for By Report codes

By Report codes are either new codes or unspecified/unlisted codes about which BWC does not have enough information to assign a specific fee. Currently, all By

Report codes are priced at \$0. By Report coded services must be processed under the protocols set forth in the “**BR/NRC/NC coded services**” section of this chapter.

2) Negotiated Reimbursement Rates

Negotiated reimbursement rates are required for designated all-inclusive per diem codes, such as nursing home and home infusion therapy services. It also may be necessary for an MCO to negotiate a fee with a provider that will not accept BWC’s fee schedule. For example, DME vendors may request a fee higher than the BWC fee when the vendor’s wholesale cost is higher than the BWC fee. Out of state, non BWC certified providers may request payment above the fee schedule. In either case, MCOs must attempt to negotiate fees. It may be necessary to initiate a cost comparison of the service/supply to determine an equitable reimbursement rate. It must always be kept in mind that BWC cannot guarantee fees in writing, sign a contract with a vendor (except as documented in Rule 4123-6-46) and cannot pay for services before the service/supply has been provided. It may be appropriate to request a copy of the invoice from the provider for high priced supplies to determine the amount of the mark up by the provider. Supplies that are billed for high amounts of reimbursement should be negotiated. However, it is not necessary to negotiate reimbursement for every supply or those for which the billed amount appears to be reasonable.

h. Ambulatory Surgical Centers (ASC)

1) Ambulatory Surgical Center and Ambulatory Surgery Facility

Rule 4123-6-37.3 establishes a mechanism for reimbursement to ambulatory surgical centers. ASCs certified for Medicare participation by their state’s Department of Health are eligible to provide services to Ohio injured workers.

- Ambulatory Surgical Center (ASC) providers receive reimbursement according to BWC’s ASC fee schedule and must be certified by the Centers for Medicare and Medicaid Services, formerly United States Health Care Financing Administration, as an ambulatory surgical center for purposes of reimbursement and enrollment. CMS certifies ASCs that are qualified to provide services and reimbursement for Medicare covered procedures. BWC will continue to follow CMS requirements and definition of an ASC.
- Ambulatory Surgery Facility (ASF) providers in Ohio must be licensed by the Ohio Department of Health (ODH) under section 3702.30 of the Ohio Revised Code; however, they do not participate in the Medicare Program. BWC follows these requirements and does not enroll an ASF in a separate category of service or provider type and does not reimburse ASF providers. BWC will continue to follow ODH requirements and definitions of an ASF.

2) Reimbursement Methodology

Effective for dates of service beginning 04/01/2009, BWC reimburses ASC services using a modified version of Medicare’s ambulatory surgical center payment system. The modifications adopted by BWC are specified in Ohio Administrative Code 4123-6-37.3.

To view the current and previous ASC rules go to www.ohiobwc.com. Additional details of the methodology are noted below:

Laboratory services should be reimbursed at the BWC fee schedule amount for the CPT® code only if the service is medically necessary, the ASC laboratory is certified to perform the procedure, the laboratory services is related to the allowed injury and the physician of record or any treating physician requests the service.

Multiple procedure discounting will be applied if procedure is included in the multiple procedures discounting provision. For services eligible for this provision (Y in column titled Subject to Multiple Procedure Discounting), BWC will reimburse 100% of the applicable reimbursement rate for the primary procedure and 50% of the applicable reimbursement rate for remaining procedures. The primary procedure is the one with the highest reimbursement rate. The services not eligible for the multiple procedures discounting provision (N in column titled Subject to Multiple Procedure Discounting) will be reimbursed at 100% of the applicable reimbursement rate.

BWC will reimburse the ASC facility for greater than four procedures when related to the injured workers claim, approved via the C-9 process and correctly reported based on the official outpatient coding guidelines.

The following modifiers may be utilized by ASCs effective April 1, 2012:

LT – left side	T1 – left foot, second digit
RT – right side	T2 – left foot, third digit
E1 – upper left, eyelid	T3 – left foot, fourth digit
E2 – lower left, eyelid	T4 – left foot, fifth digit
E3 – upper right, eyelid	T5 – right foot, great toe
E4 – lower right, eyelid	T6 – right foot, second digit
FA – left hand, thumb	T7 – right foot, third digit
F1 – left hand, second digit	T8 – right foot, fourth digit
F2 – left hand, third digit	T9 – right foot, fifth digit
F3 – left hand, fourth digit	TA – left foot, great toe
F4 – left hand, fifth digit	50 – Bilateral procedure
F5 – right hand, thumb	52 – Reduced Services
F6 – right hand, second digit	59 – Distinct procedural service
F7 – right hand, third digit	73 – Discontinued ASC procedure prior to the administration of anesthesia (terminated procedure)
F8 – right hand, fourth digit	74 – Discontinued ASC procedure after the administration of anesthesia (terminated procedure)
	76 – repeat procedure or service by same physician
	77 – repeat procedure by another physician
	91 – repeat clinical diagnostic laboratory test

Encounter Reporting Examples

The following examples are provided to assist facilities with understanding how services should be reported under the revised requirements. BWC has eliminated many “BWC customized” requirements so that billing protocols now mirror HIPAA and CMS billing guidelines for ASCs.

Bilateral Procedures

Bilateral procedures should be reported with modifier -50. For those services included in the multiple procedures discounting provision payment will be 150% of the applicable reimbursement rate. For services excluded from the multiple procedures discounting provision payment will be 200% of the applicable reimbursement rate.

Example: Bilateral lumbar transforaminal epidural injections are administered. The correct way to bill this bilateral procedure is CPT code[®] 64483 50. Do not bill CPT code[®] 64483 and CPT code[®] 64483 LT or CPT code[®] 64483 RT and CPT code[®] 64483 LT.

Multi-level Spinal Procedures

Example: Lumbar transforaminal epidural injections are administered at L1, L2 and L3. The correct way to bill these procedures that have been performed is CPT code[®] 64483, CPT code[®] 64484 59 and CPT code[®] 64484 59. Do not use modifiers L1, L2 or L3.

Example: Bilateral lumbar transforaminal epidural injections are administered at L1, L2 and L3. The correct way to bill these procedures that have been performed is CPT code[®] 64483 50, CPT code[®] 64484 50, 59 and CPT code[®] 64484 50, 59. Do not use modifiers L1, L2 or L3.

Multiple Tendons, Ligaments, Muscles or Joints

Example: Excision of four finger tendons; right thumb, right 2nd digit, right 3rd digit, right 4th digit. The correct way to bill these procedures are CPT code[®] 26180 F5, CPT code[®] 26180 F6, CPT code[®] 26180 F7, and CPT code[®] 26180 F8. Do not use modifiers J1-J4.

Example: Excision of four finger tendons: right thumb flexor and extensor tendons, right 2nd digit flexor and extensor tendons. The correct way to bill these procedures are CPT code[®] 26180 F5, CPT code[®] 26180 F5 59, CPT code[®] 26180 F6, and CPT code[®] 26180 F6 59. Do not use modifiers J1-J4.

HCPCS Level II to CPT[®] Crosswalk

There are four HCPCS Level II codes included in the CMS ASC PPS List of Covered Services for which there are alternative CPT[®] codes available for reporting. BWC is instructing ASCs to report the CPT[®] code rather than the HCPCS Level II code for the following codes:

HCPCS Code – do not report	CPT® Code – report to BWC
G0247 – Routine foot care	97597, 97598, 97602, 97605 or 97606
G0260 – Injection for sacroiliac jt	27096
G0268 – Removal of impacted ear wax	69210
G0289 – Arthroscopy, loose body	various, report appropriate CPT codes based on medical record documentation

D. MCO INVOICING INSTRUCTIONS

Reference the EDI 837 Transaction Guidelines & Data Definition Documents.

E. MEDICAL CODING GUIDELINES

1. Coding Overview

HPP requires that BWC establish standard medical coding for reporting diagnoses and medical treatment (billing). MCOs and providers must adhere to BWC’s medical coding standards for reporting and billing purposes.

2. Diagnosis Codes

Effective October 1, 2011 BWC will recognize the 2012 version of the International Classification of Diseases (ICD-9-CM). An ICD-9-CM code is:

A three, four or five-digit numeric code that represents a uniform, international classification system of coding disease and injury diagnoses.

ICD-9-CM coding is the assignment of a numerical designation to a medical diagnosis and is used to report allowed, non-allowed or disallowed/denied conditions.

3. ICD-9-CM System Currency

Ensure the utilization of the International Classification of Diseases Clinical Modification (ICD-9-CM) for all diagnosis(es) coding. In conjunction with BWC, all MCO systems must update with the annual revision of the ICD-9-CM codes, effective October 1 of the respective year.

4. Billing Requirements

The provider must ALWAYS bill the actual diagnosis (es) treated for data integrity and for medical fee bill auditing purposes. The provider must provide medical evidence to support the billed ICD-9-CM codes as requested by BWC. Each line item of a practitioner’s bill is required to contain the appropriate ICD-9-CM diagnosis code...

BWC will accept “V” codes for the principal diagnosis on all bills. The MCO must utilize the 776 EOB override on all V code bills. BWC will not accept “E” codes for the principal diagnosis. E and V codes can be accepted as the secondary diagnosis on both inpatient and outpatient bills.

Providers may bill with non-allowed diagnoses, which, after review by the MCO, are determined to be eligible for reimbursement. If a bill with a non-allowed diagnosis is considered eligible for reimbursement, the MCO must utilize the 776 EOB. This determination is the responsibility of the MCO.

a. Utilization of EOB 776

EOB 776 is an override explanation of benefits code which is defined as: **payment is being made for a non-allowed, but related condition.** The MCO must use the 776 override EOB if the MCO determines that it is appropriate to reimburse for treatment of a condition that is not allowed in a claim, and has supporting medical documentation to substantiate their determination to override and pay the bill.

1) Application of the Miller Criteria with EOB 776

- The Miller criteria must be applied on a request-by-request basis.
- Subsequent court cases determined that Miller does not excuse the requirement for formal allowance of conditions. The most important factor in considering treatment requests for non-allowed conditions is whether the requested treatment is for a specific body part or psychiatric/psychological condition as opposed to a generalized condition.
- When a specific treatment is requested for the allowed conditions in a claim, (such as diagnostic studies, treatment and/or rehabilitation for the specific allowed conditions in the claim), the "reasonably related" prong of the Miller test is satisfied.
- When specific treatment is requested for non-allowed conditions in a claim, the "reasonably related" prong of the Miller test is satisfied if the services requested are:
 - √ for generalized condition(s) (e.g. diabetes, hypertension, obesity); and
 - √ treatment of the generalized condition(s) would have a positive impact on the treatment outcome of the allowed conditions in the claim.
- When a specific treatment is requested for non-allowed conditions in a claim, and the services requested are for specific body part(s) or psychological/psychiatric condition(s), (such as meniscus tear, herniated disc, etc.) the "reasonably related" prong of the Miller test is NOT satisfied. Treatment should NOT be further considered for authorization unless the claim is additionally allowed for the specific body part(s) or psychological/psychiatric condition(s).
- All medical evidence reviewed must be clearly documented in the V-3 claim notes showing that Miller criteria were applied (See section VIII Recommendations for detailed instructions)
- Eligibility of services must be evaluated solely upon meeting the three pronged test.
- The Miller criteria do not sanction approval of psychological treatment when there is not a psychological condition allowed in the claim. However, Miller must be applied to requests for psychological services when a psychological condition is allowed in the claim
- MCOs shall also utilize the 776 EOB override when treatment not requiring prior approval is provided and billed with a non-allowed ICD-9-CM code if the provider's documentation supports that the treatment and the non-allowed condition is related to the allowed diagnosis.

2) Examples of appropriate use of EOB 776

a) Treatment was authorized by an MCO based on Miller criteria for a condition not specifically allowed in the injured worker's claim, but related to the allowed condition. If the ICD-9-CM code for the previously identified, related condition is submitted on the bill, the MCO shall use EOB 776.

- i.) An injured worker develops a post-operative infection which may resolve within a few weeks. Treatment could require oral and/or intravenous antibiotics. The bills should be paid using EOB 776. If an injured worker develops a post-operative or post-injury condition such as osteomyelitis which would require long-term treatment, the MCO must pay the bills using EOB 776, but shall work with the customer service team regarding the need for the additional condition allowance.
- ii.) An injured worker develops post-operative complications such as deep vein thrombosis (DVT) or pulmonary embolism (PE) which could require re-hospitalization for anti-coagulation, placement of Greenfield filter, and nursing care for blood level of oral anti-coagulation medication management, rehabilitation, or assistance with activities of daily living. The MCO shall pay the related bills using EOB 776 and then work with the customer service team regarding the need for the additional claim allowance.
- iii.) An injured worker develops complications related to treatment for the allowed conditions; for example: injured worker has an adverse reaction to the medications prescribed for the treatment of the allowed conditions. The related bills shall be paid using EOB 776. If the condition requires continuing treatment, the MCO shall work with the customer service team regarding the need for an additional claim allowance.
- iv.) An injured worker has a generalized condition such as diabetes or hypertension that is not an allowed claim condition. As a result of treatment/surgery for the allowed condition, the injured worker's generalized condition is no longer under control. The MCO shall pay the related bills for the treatment of the generalized condition using EOB 776 until the generalized condition is stabilized. However, if there is likely to be long term treatment of the complication that may later be considered to be related to the claim, a request for an additional allowance is probably necessary. Payment for additional or more extensive treatment would be dependent on additional allowance and other factors in the claim. This must be viewed on a case by case basis.

b) BWC will accept valid V codes for the principal diagnosis on all bills. The MCO must utilize the EOB 776 override on all V code bills after the MCO performs an analysis confirming services meet the criteria of the Miller test.

- i.) An injured worker requires pre-operative clearance for a surgical procedure where related conditions are being evaluated. The services may be billed with a V code, such as V72.82 Other specified pre-operative examination. The MCO shall pay the bill using EOB 776.
- ii.) An injured worker received physical, occupational or speech therapy services related to an allowed claim condition. The services are billed with a V code, such as V57.1 other physical therapy; V57.21 Encounter for occupational therapy; or V57.3 Speech therapy. The MCO shall pay the bill using EOB 776.
- iii.) An injured worker is receiving chemotherapy or radio-therapy for treatment of an allowed claim condition. The services are billed with a V code, such as V 58.1 Encounter for antineoplastic chemotherapy and immunotherapy or V58.0 Radiotherapy. The bill should be paid using EOB 776.
- iv.) The MCO authorizes a hospitalization for the removal of internal fixation device (surgical hardware) placed in a previous surgery to stabilize the injured worker's allowed condition of fracture of the shaft of the femur, coded as 821.01. Because hospitals code the diagnosis from the medical records for the current hospitalization, V54.01 Encounter for removal of internal fixation device, is listed on the hospital bill as the diagnosis. V54.01 is not a match to the allowed claim condition, coded as 821.01. The MCO shall review the hospital record to determine if the removal of the surgical hardware is related to the allowed claim condition, then pay the bill using EOB 776 if the review substantiates that the treatment was related to the allowed claim condition.

c). Application of EOB 776 may be appropriate for services rendered when an injured worker has an allowed diagnosis and the injured worker has symptoms indicating that further diagnostic studies are necessary to determine if a more extensive work related injury than previously identified has occurred. The following expands upon Rule 4123-6-31(F): "Payment for x-ray examinations (including CT, MRI, and discogram) shall be made when medical evidence shows that the examination is medically necessary either for the treatment of an allowed injury or occupational disease, or for diagnostic purposes to pursue more specific diagnoses in an allowed claim. Providers shall follow all bureau prior authorization policies in effect at the time when requesting authorization and payment for such studies."

If a new condition is not found, but the diagnostic study was prior authorized by the MCO in relation to the allowed claim condition, the bill is payable upon presentation according to the following guidelines:

- The bill may be coded with the allowed condition in the claim which was the diagnosis recognized at the time of prior authorization of the diagnostic study **or consult**.
- If the ICD-9 code used on the bill is one that is not already allowed in the claim, the MCO should pay the bill utilizing EOB 776, if appropriate, according to the criteria for application of this EOB. However, for any bills received for treatment/services that required and received prior authorization, if the bill received does not match the service/treatment that was prior authorized, EOB 776 should not be applied. The bill should be rejected.

If a new condition is found and a consult and/or testing was prior authorized, accepted coding conventions allow that the service may be billed with the ICD-9-CM code for the newly identified condition OR the allowed condition for which the consult or diagnostic test was indicated. In either circumstance, the guiding principle that determines payment of the bill is based on the fact that the consult or diagnostic study was prior authorized in relation to the allowed condition in the claim. For example:

- i.) A claim is currently allowed for strain of the knee, coded as 844.9. The injured worker has continued symptoms suggesting a more serious injury. The treating physician requests and receives authorization for a diagnostic arthroscopy of the knee. During the procedure, the physician notes a tear of the anterior cruciate ligament (ACL) and repairs the ligament. The provider bills with the diagnostic code of 844.2 for the tear of the ACL. The MCO shall reimburse the surgical arthroscopy, which includes repair of the torn ACL, using EOB 776. Services for further treatment for the new condition should not be paid, however, until the new condition is allowed in the claim. The MCO shall contact the BWC customer service team regarding the need for the additional claim allowance.
 - ii.) A claim is currently allowed for shoulder sprain coded as 840.8. The injured worker has continued symptoms suggesting a more serious injury. The treating physician orders an MRI which shows a tear of the rotator cuff. The provider bills for the MRI with the diagnosis of 840.4 for the tear of the rotator cuff. The MCO shall reimburse for the diagnostic service with the ICD-9-CM code for the new condition using EOB 776. Services for further treatment for the new condition should not be paid, however, until the new condition is allowed in the claim. The MCO shall contact the BWC customer service team regarding the need for the additional claim allowance.
- d) From time to time, the number of digits in an ICD-9-CM code is expanded. For example a three digit code may be expanded to four digits or a four digit code is expanded to five digits. The proper application of coding principles

requires the highest level of specificity or maximum number of digits be assigned for a code. If an injured worker's claim has been allowed for a condition that is identified by an ICD-9-CM that has been expanded subsequent to the claim allowance, the MCO must use the 776 EOB override if the provider bills with the current expanded code.

3) Recommendations

a) The MCO shall use EOB 776 as defined in this policy for payment of bills for treatment of non-allowed conditions.

b) Each use of EOB 776 override must be reviewed on a case by case basis.

c) Prior to using EOB 776, the MCO shall perform the following steps:

- Contact the provider for medical records, if not available
- Obtain documentation and have imaged into claim file
- Obtain a review of the medical documentation by the MCO nurse or coder who will enter a V-3 note into the claim file. The note shall document the reviewer's rationale for utilizing EOB 776, citing the specific documents used in the decision and an analysis of how the three prong Miller test was satisfied to justify payment of the medical services in the claim.

d) The MCO shall not use EOB 776 based solely on the request of the provider. The MCO shall follow the steps as noted in recommendation "C" prior to using EOB 776.

e) MCOs must not ask or require providers to change ICD-9-CM codes, but the MCO must contact the provider to ascertain whether there could be a billing or typographical error, or if a new condition is being requested, and communicate to the provider the possibility of bills submitted with non-allowed conditions being denied.

f) Inappropriate use of EOB 776 may result in recovery from the MCO. The MCO may be responsible for payment for any services authorized by the MCO for an unrelated or disallowed diagnosis using override EOB 776.

g) The application of EOB 776 will not allow payment of bills containing invalid ICD-9-CM codes (as listed in the *BWC Invalid ICD-9 Codes* document). The MCO must request an adjustment of the denied bill if the bill should be paid.

h) Services provided for conditions not allowed in an injured worker's claim are the responsibility of the injured worker. However, if a bill is submitted with a diagnosis not allowed in the injured worker's claim, that does not automatically mean the injured worker should be billed. The MCO must explore with the provider the possibility that the claim allowance needs to be updated, perhaps proactively. If a proactive allowance is not appropriate, the CSS should contact the injured worker about submitting a C86 Motion request

for an additional allowance. If the service is appropriate, but the provider or the provider's billing personnel have made an ICD-9 or typographical error when billing, this can be discussed when contacting the provider's office.

i) In catastrophic (CAT), or settlement claims, it may be appropriate to use the EOB 776. The MCO shall place a V3 note in the claim stating the bill was paid pending settlement or as part of a CAT claim, and the reason use of EOB 776 is appropriate.

4. Measurements

BWC's Medical Services Division will regularly monitor the usage of the EOB 776 override code for appropriateness and to ensure complete medical records were obtained and justification is documented in case notes.

5. ICD-9-CM Groups

BWC groups ICD-9-CM codes into numeric sets. Injury or disease codes that are similar in nature or involve the same body part are grouped together. All codes in that group are interchangeable and can be used for both allowance and reimbursement purposes.

When using the ICD-9-CM group document, keep these two things in mind: An ICD-9-CM code may appear only in one ICD-9-CM group; and if an ICD-9-CM code is not listed in any group, it means that code is considered a group by itself.

Copies of a document containing BWC's ICD-9-CM groups can be accessed on www.ohiobwc.com. Questions about the ICD-9-CM groups document can be directed to BWC Policy and Support at (614) 466-0498 or (614) 995-5023.

6. General Requirements

a. Invalid ICD-9-CM Codes

BWC does not recognize supplementary classification "E" and "V" codes as allowed conditions.

b. Justification for Identifying Invalid ICD-9-CM Codes

BWC has identified 'invalid ICD-9' codes that are not used for reporting an injury/condition. Many of these 'invalid ICD-9' codes are not typically related to an industrial injury or occupational disease.

A BWC 'invalid ICD-9' code is defined as:

- A code for an injury/condition that is not causally related to an industrial injury or occupational disease.
- An unspecified injury/condition or site code therefore a more specific code exists.
- A multiple injury/site code. Reported injuries/conditions with more than one injury/site are assigned individual codes.

Copies of a document containing 'invalid' ICD-9-CM codes can be ordered by contacting the forms and publications department at 1-800-OHIOBWC (1-800-644-6292) or downloaded via the Internet at <http://www.ohiobwc.com> or <http://www.bwc.state.oh.us>.

Questions about the invalid ICD-9-CM codes document can be directed to BWC Policy and Support.

G. CLINICAL EDITING

Clinical editing, a critical part of identifying and eliminating inappropriate payments, is a process of reviewing bills for appropriate coding and reimbursement and restricts how a procedure can be reimbursed. Components of clinical editing may go beyond those noted in the MCO's medical bill editing criteria package below. For example, medical necessity should determine reimbursement eligibility for the physical medicine treatments or modalities, not the number of the modalities. Three modalities might be medically necessary for one injured worker, but only one for another. The provider reports what was done and the MCO determines if reimbursement is appropriate for the allowed conditions in the claim.

Should the MCO receive an appeal to an edit, follow the steps contained within the established Grievance process.

MCOs are not required to follow The Centers for Medicare and Medicaid Services (CMS) medical editing criteria guidelines. However, all MCOs are required to have a nationally recognized, medical bill editing criteria package and shall supply the rationale behind the editing to the provider and identify the software vendor. MCOs must update their clinical editing software yearly to include CPT additions, changes and deletions. The MCO's clinical editing shall contain but is not limited to the following:

- 1. Valid provider type:** The MCO shall be able to identify that the provider of the services has reported codes that are valid for that provider type and within his/her scope of practice. **Example:** An ambulance provider should not bill codes for performing physical therapy.
- 2. Correct provider coding:** The MCO shall be able to discern patterns that a provider has reported codes that do not accurately describe the procedure performed or service provided. **Example:** A provider frequently bills a high level evaluation and management code, or frequently bills both an evaluation and management service and one or more Chiropractic or Osteopathic manipulation treatment codes, on the same date of service. Provider documentation shall support the codes that are billed.
- 3. Modifiers:** Modifiers are 2 digits (letters or numbers) used with CPT codes to identify special services or circumstances. Modifiers indicate that the services or procedures performed have been altered by specific circumstances. MCOs shall apply EOBs to prohibit payment of an incorrect modifier. **Example:** Modifier -50 bilateral procedure is appended to a code that could not be performed bilaterally
- 4. Multiple procedure pricing:** MCOs shall follow the following criteria for use of Modifier -51 multiple procedure pricing shall be based on the determination of the primary, secondary, third, fourth and fifth procedures. The primary procedure is the one that has the highest relative value unit or highest paid amount per unit, not the procedure with the highest billed amount. The primary procedure will be priced at 100 percent of the allowed amount. The second, third, fourth and fifth procedures will be priced at 50 percent of the allowed amount. The sixth procedure and beyond will be priced at 25% of

the fee. Reimbursement will not automatically be made for more than five procedures. Any exception shall be determined to be reimbursable by the MCO. Modifier –51 may be applied to all CPT codes except E/M codes and those listed in CPT Appendix D (Add On Codes) & E (Exempt from Modifier –51 codes). Add on and exempt from modifier -51 codes shall be priced at 100 percent, in addition to the primary procedure; however, are counted in the number of procedures reimbursed.

5. **Units of Service** The MCO shall review whether units of service billed are appropriate for the allowed conditions and meet the Miller Criteria. The Centers for Medicare and Medicaid Services' (CMS) Medically Unlikely Edits, which pertain to procedures, DME, etc., and Maximum Allowable Units for medication dosage guidelines are used as for determining standard units billed for a given service.
6. **Follow-up days - also called global period:** The BWC shall be able to determine the period of time when medical services are considered to be part of the surgical procedure and are not reimbursed in addition to the surgical procedure. **Example:** The surgical procedure **includes post-op care of 10 days for a minor procedure and 60 days for a major procedure.** During that time period, office visits to the same provider or another provider rendering post operative care are considered as part of the original surgical fee.
7. **Unbundling - also called fragmenting or down-coding:** The MCO shall be able to determine that a provider has reported multiple codes when all services should be included in one code. The MCO shall be able to detect the unbundling, re-bundle using the appropriate code(s) and price at the re-bundled procedure fee. **Example:** Billing separately for services which are a necessary part of the surgical or other procedure
8. **Mutually exclusive procedures** - The MCO shall be able to determine procedures that, by definition, cannot be billed together at the same time. **Example:** Two codes are billed for the same date of service, one for osteopathic manipulation to one to two body regions and one for three to four body regions.
9. **Gender** - Most CPT codes are appropriate for male or female but some are specific to one gender. The MCO shall be able to identify procedures appropriate to only one sex.
10. **Place of Service** - The MCO shall be able to identify where the services were performed and reimburse the provider according to the correct two digit place of service. **Example:** Non-Facility and/or Facility fee.
11. **Procedure appropriate for diagnosis** - This is unique to workers' compensation and affects prior authorization more than the clinical editing; however, MCOs shall be able to identify procedures appropriate for the allowed conditions in the claim. **Example:** A CPT code for performing a craniotomy would not be allowed if the allowed diagnosis is knee sprain.

Rent to purchase - The total amount of the rental cost shall not exceed the total purchase price as established by MCO and vendor negotiations.

BWC considers DME to be purchased when rental has reached the purchase fee that was effective at the time the equipment was initially rented. BWC does not accept a provider's percentage reduction from the rental fees already paid which result in BWC

payment of additional monies for the purchase of the equipment beyond the BWC purchase fee.

Certain items of DME listed on the professional provider fee schedule are rented only (RR modifier) and may not be purchased. These items do not have an NU modifier identified with the HCPCS code. For further explanation, refer to the preamble of the current professional provider fee schedule.

12. Codes that are valid for the date of service: Codes are added and deleted yearly; therefore providers shall report codes that are valid for the date of service. MCOs shall be able to identify appropriate valid and invalid dates for each code

13. Reimbursement of splint and casting supplies

BWC follows CPT® guidelines for the musculoskeletal system for fractures and dislocations as provided in the surgery section of the CPT® book. The instructions state fracture and dislocation care includes the application and removal of the initial cast. BWC will reimburse HCPCS level II casting supply codes (Q codes) when supplies are indicated while providing reapplication of casts or splints. Q codes will only be separately reimbursed if used for subsequent replacement for the treatment of fractures and dislocations. The HCPCS Level II casting supply codes (A codes) will become non-covered codes.

14. Reimbursement for Interpretation of Emergency Room X-rays

It is common for injured workers to seek treatment for injury(s) that include performance and interpretation of x-rays in the emergency room. (ER)

Certain procedures such as x-rays are a combination of the procedure being performed (technical component (TC) and a physician interpretation component, identified by a modifier-26.) Reimbursement of the technical component of an x-ray will be made to only one provider.

In situations where more than one physician provides interpretation of the same emergency room x-ray for the same IW, for the same or different dates of service, the MCOs shall reimburse the radiologist.

In addition, the MCOs shall reimburse the ER physician for the x-ray interpretation when the interpretation results in treatment of the injured worker. Examples include:

- ER physician orders X-ray that result in diagnosis of fracture. ER physician applies cast.
- ER physician orders x-ray. No fracture is visible on x-ray. ER physician diagnoses strain/sprain and orders non-steroidal anti-inflammatory medication for pain.

If an ER physician orders an x-ray, does not treat the injured worker based on results of the x-ray and refers the IW to a physician specialist for the interpretation and treatment, BWC will not reimburse the ER physician for the interpretation of the x-ray since it did not result in treatment by the ER physician.

15. Incidental Procedures

An incidental procedure is performed at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.

16. Utilization Parameters

- Coding multiple new patient E&M codes
- Coding multiple consult codes
- Coding multiple E&M codes on same date of service
- Preventive counseling codes
- Frequency of service

17. Unlisted Procedures

Unlisted procedures are those that identify CPT and Level II HCPCS services that do not have a more specific code. Any use of an unlisted code will require a report which describes the service or procedure.

18. Observation Days

For the purposes of Rule 4123-6-01 relating to hospitals, “outpatient” means: The injured worker is not receiving inpatient care, as “inpatient” is defined in paragraph (CC)(1) of this rule, but receives outpatient services at a hospital. An outpatient encounter cannot exceed seventy-two hours of uninterrupted duration.

H. MEDICAL PROCEDURE CODES

1. Billing Codes

BWC recognizes the following billing codes for reporting/billing medical goods and services:

Hospital services*	Revenue codes ICD-9-CM procedure codes HCPCS Levels I, II and III codes (CPT, HCPCS and local codes)
Practitioner services	HCPCS Levels I, II and III codes (CPT, HCPCS and local codes)
Ambulance, dental, DME, medical supplies, orthotics, prosthetics, vision services, and others	HCPCS Level II codes (A-V codes)
Home health, nursing home, vocational rehab and other miscellaneous services	HCPCS Level III codes (W, Y and Z codes)
Drugs	HCPCS level II codes

2. Hospital Codes

a. Revenue Codes

Revenue codes are three-digit numeric figures used to report inpatient and outpatient hospital services. Covered and non-covered revenue codes can be found in Chapter 3, Section B.11 of the Provider Billing and Reimbursement Manual.

*Some revenue codes require a corresponding HCPCS code for reporting purposes on outpatient hospital bills. These revenue codes are noted in Chapter 3, Section B.12 of the Provider Billing and Reimbursement Manual

The following services are not billable through the use of revenue codes:

- Professional Services - Use HCPCS level I, II or III codes to bill for services provided by physicians, dentists, podiatrists, optometrists and psychologists.
- Home Health, Hospice and Nursing Home Services - Use HCPCS Level III codes to report these hospital based services.
- Ambulance, DME Services - Use HCPCS Level II codes to report these hospital based services.
- Outpatient Pharmacy Services - MCOs are not responsible for these services. Coordinate all outpatient pharmaceuticals through Traumatic Brain Injury (TBI) Programs - Use HCPCS Level III codes to report these hospital based services.

b. ICD-9-CM Procedure Codes,

ICD-9-CM procedure codes describe procedures used for the treatment of illness and injury. ICD-9-CM procedure codes are used when reporting surgery and procedures on inpatient hospital bills. When two or more procedures are reported, the principal procedure is identified by the one that relates to the principal diagnosis.

3. HCPCS Codes

To report procedures and/or services provided to injured workers, BWC recognizes the Centers for Medicare and Medicaid's Common Procedure Coding System (HCPCS). This system is comprised of HCPCS Level 1 procedure codes from the American Medical Association's *Current Procedural Terminology* (CPT) manual, as well as the HCPCS Level II codes, developed for Medicare billing, and HCPCS Level III codes unique to BWC billing.

a. HCPCS Level 1

CPT codes are five-digit numeric codes.

Service Type	CPT Code Range
Anesthesia	00100-01999
Surgery	10040-69990
Radiology	70010-79999
Pathology	80048-89399

Physical Medicine	97001-98999
General Medicine	90281-96999 99000-99499

Effective for dates of service beginning, January 1, 2012, BWC and MCOs will accept 2012 HCPCS Level I (CPT) billing codes as established by the American Medical Association (AMA).

b. HCPCS Level 2

Five-digit alphanumeric codes (A-V codes).

Created by CMS for Medicare and other third party reporting/reimbursement.

A list of HCPCS Level II modifiers BWC recognizes are identified in the preamble to the professional fee schedule (Rule 4123-6-08).

Effective for dates of service on or after January 1, 2012, BWC and MCOs accept 2012 HCPCS Level II billing codes as established by CMS

MCOs should attempt to direct injured workers to in-state BWC certified providers whenever possible for DME, medical supplies, orthotics, prosthetics, vision services, and other supplies and services. Durable medical equipment should be purchased from non-certified or out-of-state vendors **only** in situations when comparable equipment is not available in Ohio or the injured worker lives out-of-state. DME may require maintenance or repair; therefore it is more practical and convenient for the IW and often more cost effective to utilize a vendor in or near the community where the injured worker lives rather than an out-of-state provider.

Note: For payment of a prosthetic, the MCO does not need to use override EOB 753: *These services were rendered as part of an authorized rehabilitation program.*

Two EOBs were created or revised to reflect partial payment of bills for either the rental or purchase of DME equipment. These are informational, not denial, EOBs so they can only be attached to lines that the MCO wants to pay.

- **EOB 503:** *Payment for the rental of this equipment has been made up to the allowed purchase amount.* This EOB is used when the total billed for rental equipment exceeds the amount allowed for the purchase of the equipment. While BWC no longer sets a maximum length of time for rental of items such as TENS units, MCOs are not permitted to authorize payment for rental at an amount greater than the cost to purchase the item. If a provider bills above that amount, the MCO shall authorize payment at an amount that will not exceed the purchase price and attach this EOB.
- **EOB 567:** *Payment for the purchase of this equipment has been made up to the allowed purchase amount.* This EOB is used when the amount billed for the purchase of equipment exceeds the maximum allowed purchase price. The MCO shall authorize payment at an amount that will not exceed the allowed purchase price and attach this EOB.

c. HCPCS Level 3

- Five-digit alphanumeric codes (W, Y and Z codes).

- Developed by BWC, these codes are unique to the Ohio workers' compensation system.
- BWC does not recognize modifiers for HCPCS Level III codes.
- Effective for dates of service on or after January 1, 2012, BWC and MCOs accept 2012 HCPCS Local Level III billing codes. Local Level III codes are descriptive terms and identifying codes for services and equipment specific to Ohio workers' compensation and are published in Chapter 2 of the Billing & Reimbursement Manual.

I. BILLING WITH MODIFIERS

Two-digit numeric modifiers are used in conjunction with the five digit base CPT and HCPCS Level II codes to report some modification to the base procedure or unusual circumstance. Some modifiers, when reported, may impact the level of reimbursement. Every modifier that can be billed to BWC has been assigned to one of the following classifications:

- Role: Describes the provider: - 80 (Assistant Surgeon), - 62 (Co-Surgeon)
- Location: Identifies the part of the body treated: LT (left), - , FA left hand thumb
- Information: Describes the procedure: - 51 (Multiple Surgical Procedure), - , -22 (Increased procedural services)

Cambridge can accept up to four modifiers per line item but when more than one modifier is billed, each modifier must be appropriate for the procedure and logical in combination with the other modifiers. Two role or location modifiers cannot be billed on the same line or the bill will be rejected on an 824 with **EOB 110** (Payment is denied as the combination of modifiers is invalid)

Through the use of modifiers, BWC can recognize special services that have been performed. Depending on the modifier used, it may alter the reimbursement rate or strictly be used as a reporting mechanism. This section outlines all modifiers recognized by BWC and the reimbursement impact of each. Providers should be instructed not to bill using two modifiers on one line and to use the modifier indicating pricing rather than informational reporting.

1. Valid Modifiers

Note: Valid modifiers for the hospital outpatient and ASC settings can be found in their respective sections of the Provider Billing and Reimbursement Manual.

- 22 Unusual procedural services
This modifier may be used when the service provided is greater than that usually required for the listed procedure. The reimbursement may not exceed 120 percent of the allowed amount. When performing bill review to determine the appropriateness of reimbursement of a procedure with modifier 22 applied, the MCO must document in notes prior to bill submission to BWC: review of the medical documentation has been completed, the process and decision criteria utilized for approval of a higher reimbursement level for the billed procedure(s), and that payment of the bill utilizing modifier 22 is appropriate.
- 23 Unusual anesthesia

- 24 Unrelated evaluation and management by the same physician during a postoperative period. The unrelated E/M service must, however, be for an allowed condition in the claim. No additional payment will be made for the use of this modifier.
- 25 Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure. This modifier is most often used, on an occasional basis, in conjunction with osteopathic or chiropractic manipulative treatment codes and with Emergency Department codes. It is used in the ED when treatment does not include the surgery. No additional payment will be made for the use of this modifier.
- 26 Professional component
- TC Technical Component - This modifier refers to the technical portion of a total procedure.
- 30 Anesthesia component
Report regional and general anesthesia services by adding modifier -30 to the five-digit CPT anesthesia procedure code. Bill modifier -30 in either of the following cases:
 - a) A certified registered nurse anesthetist (CRNA) performs the anesthesia service without supervision of an anesthesiologist because an anesthesiologist was not employed or was not under contract by that hospital;
 - b) An anesthesiologist performs the anesthesia service.
 Modifier -30 may be paid to only one provider. A second provider cannot bill this modifier or any other anesthesia modifier. This modifier pays 100 percent of the total allowed for the anesthesia service for the surgical procedure.
- 50 Bilateral procedure - This modifier pays 150 percent of the total allowed amount for the procedure performed.
- 51 Multiple procedures
Pricing is based on the determination of the primary, secondary, tertiary, etc. procedures. The primary procedure will be paid at 100 percent of the allowed amount. The second, third, fourth and fifth procedures will be paid at 50 percent of the allowed amount. Reimbursement will not automatically be made for more than five procedures. Any exception must be determined to be reimbursable by the MCO and handled as an adjustment. Modifier -51 may be applied to all CPT codes except E/M codes and those listed in CPT Appendix E (Add On Codes) & F (Exempt from Modifier -51 codes).
- 52 Reduced services-Reimburses 50% of fee
- 53 Discontinued procedure. Reimburses 50% of fee
- 54 Surgical care only- 70% reimbursement to surgeon for operative and intra-operative care
- 55 Postoperative management only- 20% reimbursement when rendering only post-operative care. Multiple providers for post-operative care will divide 20%
- 56 Preoperative management only-10% reimbursement for pre-operative evaluation component of a global surgical package, when performed by a physician other than the surgeon
- 57 Decision for surgery. This modifier is used with an E/M code when the E/M service resulted in the initial decision to perform surgery. It is used in the ED when treatment includes surgery

- 58 Staged or related procedure or service by the same physician during the postoperative period
- 59 Distinct procedural service (**Note:** Use modifier –59 when an explanation of why codes should not be bundled is necessary to identify procedures/services that are not normally billed together.)
- 62 Two surgeons
The allowable is 125 percent of the global surgical procedure amount divided equally between the two surgeons). No payment will be made for an assistant surgeon.
- 66 Surgical team
- 73 Discounted Out-Patient Hospital/ASC Procedure Prior to the Administration of Anesthesia
- 74 Discounted Out-Patient Hospital/ASC Procedure After Administration of Anesthesia
- 76 Repeat procedure by same physician.
- 77 Repeat procedure by another physician
- 78 Return to the Operating Room for a Related Procedure During the Postoperative Period.
- 79 Unrelated procedure or service by the same physician during the postoperative period. New problem.
- 80 Assistant surgeon
Reimbursement will be made at the lesser of the billed amount or 20 percent of fee maximum.
- 81 Minimum assistant surgeon
Reimbursement will be made at the lesser of the billed amount or 10 percent of fee maximum.
- 82 Assistant surgeon (when qualified resident surgeon not available)
Reimbursement will be made at the lesser of the billed amount or 20 percent of fee maximum.
- 90 Reference (outside) laboratory
- 91 Repeat Clinical Diagnostic Laboratory Test
This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required.
- 95 Supervisory anesthesia
Used only by the anesthesiologist who supervises an independently enrolled, privately billing CRNA. This modifier is expected to be billed in conjunction with the CRNA billing the -QX modifier. A third provider cannot submit another bill using modifier -95, -30 or -23. This modifier pays 50% of the total allowed for the anesthesia service.
- 99 Multiple Modifiers
A report may be required when billing this modifier.
- QX Certified Registered Nurse Anesthetist (CRNA)
Used only by a CRNA who is independently enrolled and is supervised by an anesthesiologist. This modifier is expected to be billed in conjunction with an anesthesiologist billing the -95 modifier. A third provider cannot submit another bill using modifier -23, -30 or -QX. This modifier pays 50 percent of the total

allowed for the anesthesia service. (See section D of this chapter for additional detail.).

2. Level II (HCPCS/National) modifiers accepted by BWC:

-LT	Left Side
-RT	Right Side
-E1	Upper left, eyelid
-E2	Lower left, eyelid
-E3	Upper right, eyelid
-E4	Lower right, eyelid
-FA	Left hand, thumb
-F1	Left hand, second digit
-F2	Left hand, third digit
-F3	Left hand, fourth digit
-F4	Left hand, fifth digit
-F5	Right hand, thumb
-F6	Right hand, second digit
-F7	Right hand, third digit
-F8	Right hand, fourth digit
-F9	Right hand, fifth digit
-LC	Left circumflex coronary artery (Hospitals use codes 92980-92984,92995,92996)
-LD	Left anterior descending coronary artery (Hospitals use codes 92980-92984,92995,92996)
-RC	Right coronary artery (Hospitals use codes 92980-92984,92995,92996)
-QM	Ambulance service provided under arrangement by a provider of services
-QR	Repeat laboratory test performed on the same day
-QN	Ambulance service furnished directly by a provider of services
-TA	Left foot, great toe
-T1	Left foot, second digit
-T2	Left foot, third digit
-T3	Left foot, fourth digit
-T4	Left foot, fifth digit
-T5	Right foot, great toe
-T6	Right foot, second digit
-T7	Right foot, third digit
-T8	Right foot, fourth digit
-T9	Right foot, fifth digit
-NU	New equipment component reimbursement
-RR	Rental equipment component reimbursement
-RB	Replacement of a part of DME furnished as part of a repair

J. ANESTHESIA CODING CONSIDERATIONS

1. Anesthesia

General or regional anesthesia services are billed using the anesthesia five-digit (CPT) code (00100 - 01999), plus the appropriate two-digit modifier code.

If multiple procedures are performed, bill only the anesthesia CPT code of the primary procedure. If a nerve block or facet block is administered (i.e., injection; paravertebral facet joint nerve - CPT code 64442), add no modifier unless general anesthesia is provided.

2. Modifiers

General anesthesia modifiers -23, -30, -95 or -QX must accompany the appropriate anesthesia CPT code.

23	Unusual anesthesia	95	Supervisory Anesthesia
30	Anesthesia	QX	CRNA Anesthesia

Do not use modifiers -AA and -P1 through -P6 for physical status when billing BWC.

3. Calculating Anesthesia Reimbursement

Effective with implementation of the 5010 format, billing for anesthesia services will change. The quantity of time will no longer be measured in 15 minute units of provided anesthesia service. Providers are responsible for adding the minutes for the anesthesia base unit (ABU) to the minutes of the anesthesia service prior to submitting a fee bill for reimbursement. The sum of the ABU and the time will be used to calculate reimbursement. The bill for anesthesia services must reflect total /minutes (both time and base units) in the units column of the bill form.

Anesthesia Equation: Minutes + Anesthesia Base Unit) x Anesthesia Conversion Factor = Maximum Dollars Reimbursed.

The link to the Medicare assigned anesthesia base unit:

<http://www.cms.gov/center/anesth.asp>

4. 2011 Anesthesia CPT® codes

The following table lists the 2011 anesthesia CPT codes. The code with status of MCO-D is payable at the discretion of the MCO. In order to pay that code, the MCO has to apply EOB 752. The codes with status NRC are valid CPT codes, but are not covered in workers compensation claims.

CPT® codes and descriptions are copyright 2010 American Medical Association

CPT Code	Status										
00100		00524		00820		01120		01490		01920	
00102	NRC	00528		00830		01130		01500		01922	
00103		00529		00832		01140		01502		01924	
00104		00530		00834	NRC	01150		01520		01925	
00120		00532		00836	-NRC	01160		01522		01926	
00124		00534		00840		01170		01610		01930	
00126		00537		00842		01173		01620		01931	
00140		00539		00844		01180		01622		01932	
										01933	
										01935	
										01936	
00142		00540		00846		01190		01630			
00144		00541		00848		01200				+01951	
00145		00542		00851	NRC	01202		01634		01952	NRC
00147		00546		00860		01210		01636		01953	

00148		00548		00862		01212		01638		01958	
00160		00550		00864		01214		01650		01960	NRC
00162		00560		00865	NRC	01215		01652		01961	NRC
00164		00561	NRC	00866		01220		01654		01962	NRC
00170		00562		00868		01230		01656		01963	NRC
00172	NRC	00563		00870		01232		01670		01965	NRC
00174		00566 00567		00872		01234		01680		01966	NRC
00176		00580		00873		01250		01682		01967	NRC
00190		00600		00880		01260		01710		+01968	NRC
00192		00604				01270		01712		+01969	NRC
00210											
00211		00620		00882		01272		01714		01990	
00212		00622		00902		01274		01716		01991	
00214		00625		00904		01320		01730		01992	
00215		00626		00906 00908		01340		01732		01996	
00216		00630		00910		01360		01740		01999	
00218		00632		00912		01380		01742			
00220		00634		00914		01382		01744			
00222		00635		00916		01390		01756			
00300		00640		00918		01392		01758			
00320		00670		00920		01400		01760			
00322		00700		00921	NRC	01402		01770			
00326	NRC	00702		00922		01404		01772			
00350		00730		00924		01420		01780			
00352		00740		00926		01430		01782			
00400		00750		00928		01432		01810			
00402											
00404		00752		00930		01440		01820			
00406		00754		00932		01442		01829			
00410		00756		00934		01444		01830			
00450		00770		00936		01462		01832			
00452		00790		00938		01464		01840			
00454		00792		00940		01470		01842			
00470		00794		00942		01472		01844			
00472		00796		00944		01474		01850			
00474		00797	MCO-D	00948		01480		01852			
00500		00800		00950		01482		01860			
00520		00802		00952		01484		01935 and 01936			
00522		00810		01112		01486		01916			

K. BILATERAL PROCEDURES (Modifier -50)

Bilateral surgical procedures that are performed at the same operative session must be billed on one line, using the appropriate CPT code and adding modifier -50 to identify the second (bilateral) procedure with one unit of service.

Bilateral radiological procedures must be billed by using the appropriate CPT code on one line with one unit of service.

L. GLOBAL SURGICAL CARE

Services Included in Global Package

Services included in the global package may be furnished in a variety of settings, examples: Ambulatory Surgical Centers, physicians' offices, etc. The following services are not payable to the operating surgeon during the global period:

- Preoperative visits beginning with the day before a major surgery and they day of the surgery for minor procedures.
- Intra-operative services that are normally a usual and necessary part of a surgical procedure.

Postoperative visits-Follow-up visits after the surgery that are related to the recovery from the surgery that occurs within the designated postoperative period.

- Routine postoperative care
- Post-surgical pain management by the surgeon.
- Supplies, except for selected procedures.
- Miscellaneous services. Items such as dressing changes; local, incisional care; removal of operative packs, cutaneous suture and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

Note: * BWC does recognize that an IW may have a complicated postoperative period. Care for complications following surgery that are a **major and/or significant** condition **may** be considered for reimbursement within the designated postoperative period (e.g., treatment for significant post-operative infections, deep vein thrombosis, wound dehiscence, non-healing wounds, seroma or hematoma). The appropriate evaluation and management code with a modifier must be used for the service. All complications resulting in a return trip to the operating room are reimbursable. The appropriate code and modifier must be used.

M. CMS PLACE OF SERVICE CODES

The CMS 2-digit place of service codes are mandatory on the non-facility 837 bills:

01 Pharmacy
03 School
04 Homeless Shelter
11 Office
12 Home of patient
13 Assisted Living
15 Mobile Unit (A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.)
20 Urgent Care Facility
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Dept. Hospital
24 Ambulatory Surgical Center (ASC)
25 Birthing Center

26 Military Treat. Facility
31 Skilled Nursing Facility (SNF)
32 Nursing Facility (NF)
33 Custodial Care Facility
34 Hospice
41 Ambulance, Land
42 Ambulance, Air or water
51 Psychiatric Facility Inpatient
52 Psychiatric Facility, Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Place of Service

NPI Frequently Asked Questions

1) Question: Should the MCO submit the 11-digit BWC ID with the NPI when a bill is submitted with the NPI as the only identifier and the MCO is able to match the NPI to a BWC ID?

Answer: No. Only the information submitted by the provider should be submitted on the 837. Do not derive or pull data from the provider eligibility file, or the supplemental alternate identifier file to populate the 837. The new data elements (NPI, Taxonomy, and Provider Address information) should be submitted only when the provider has included them in their bill and should be submitted exactly as billed.

2) Question: How do MCOs apply clinical edits if they can't identify the provider based on the billed NPI?

Answer: The MCO must identify a single BWC provider record and apply clinical edits for all bills.

The following clarification addresses this question for several potential data combinations:

- Provider submits a valid 11-digit BWC provider number.

If a valid 11-digit BWC provider number (BWC ID) is submitted on a bill, whether or not the NPI or the taxonomy code is present, the MCO should perform all clinical editing based on the provider's eligibility information as identified by the BWC ID. The MCO should process the bill using the

BWC ID and send all provider identifiers submitted on the bill, i.e. BWC ID, NPI, taxonomy code, practice ZIP (if it is for a physical location).

- Provider submits NPI information only and it is not found in provider eligibility data.

If the BWC ID is not on the bill, but the NPI information (NPI alone, or NPI and taxonomy code) is on the bill, the MCO should look up the NPI to determine if the NPI is in the provider eligibility file created from the weekly Provider and Alternate Identifier Update Files. If the NPI is not found (i.e. has not been reported to BWC), the MCO should try to determine who the provider is, and should reject the bill back to the sender if unable to identify provider. The MCO should let the provider know that the billed NPI was not enrolled with BWC.

- Provider submits NPI only and there is a single match in the provider file data.

If the BWC ID is not on the bill, but the NPI information (NPI alone, or NPI w/taxonomy code, or NPI w/taxonomy code w/ZIP, or NPI w/ZIP) is on the bill, the MCO should determine if the NPI has a single valid match in the provider file. If a single match is found, the MCO should perform all clinical editing based on the provider's eligibility information as identified by the BWC ID. The MCO must not submit the BWC ID on the 837 when it was not submitted on the bill.

- Provider submits NPI only and there are multiple matches in provider file data.

If multiple matches are found, the MCO should contact the provider and communicate that, based on the BWC enrollment data, the bill cannot be processed without the BWC ID. The MCO should request the BWC ID from the provider. If the BWC ID is received from the provider, the MCO will then be able to process the bill. The MCO should send the 837 with both the BWC ID and the NPI (and taxonomy code and ZIP, if billed) along with an EOB that indicates that the provider was contacted and asked to provide the BWC ID due to the same NPI being attached to multiple BWC IDs. This can be incorporated into the MCO's documented reject process. BWC and MCOs will use the EOB to provide additional customer training and support for providers who wish to transition successfully to using NPI in BWC billing. The clinical editing for these bills will be done based on the BWC ID supplied by the provider.

3) Question: Why does BWC need the provider's location address information when the NPI is on the bill?

Answer: BWC is using this information to perform its crosswalk between BWC ID and NPI information.

Further clarification of this requirement:

- If the BWC ID is on the bill and the NPI is not on the bill, we do not need the provider address information at all.
- If the NPI is on the bill (whether or not the BWC ID is included), please use the following business rules:
 - Servicing provider address (from block 32 of the paper CMS-1500, or block 1 of the UB-04).

If the address on the bill is a physical location (not a PO Box), send provider address information on the 837.
Minimum to be sent is the ZIP code.

If only the 5-digit ZIP is on the provider's bill, send 5 digits. If the 9-digit ZIP is on the bill, send all 9.

- Pay-to provider address (from block 33 of the paper CMS-1500, or block 1 of the UB-04).

If the address on the bill is a physical location (not a PO Box), send provider address information on the 837.

Minimum to be sent is the ZIP code. If only the 5-digit ZIP is on the provider's bill, send 5 digits. If the 9-digit ZIP is on the bill, send all 9.