

Table of Contents

A. General	3-3
B. Practitioner Services	3-3
1. Covered Medical Service Providers	3-3
a. Physicians of Record	3-3
b. Physician Assistant (PA)	3-3
c. Advanced Practice Nurse	3-4
d. Independent Social Worker	3-4
e. Professional Clinical Counselor	3-4
f. Social Worker	3-4
g. Professional Counselor	3-4
h. Physical Therapists, Occupational Therapists, Speech Pathologists, Massage Therapists	3-4
i. Licensed Athletic Trainer	3-4
j. Non-Physician Acupuncturist	3-5
k. Urgent Care Facility	3-5
l. Ergonomist	3-5
2. Covered Vocational Rehabilitation Case Management	3-5
3. Non-covered Providers	3-6
4. Guidelines	3-6
a. Provider signature on Medical Evidence	3-6
b. Change of Physicians	3-7
c. Two Physicians treating at the Same Time	3-7
d. Treatment of Family Members	3-7
e. Multiple Visits	3-7
f. Reimbursement for In-Home Physician Visits and Physician Mobile Office Visits	3-8
g. Office Based Surgery	3-8
h. Surgical Procedures Performed in the Emergency Department	3-8
i. Unsupervised Physical Reconditioning Program and Home Exercise Equipment	3-9
j. Billing Codes	3-9
k. Telephone Call Codes (99371-99373)	3-9
l. Consultation Codes (99241-99245) and (99251-99255)	3-9
5. Anesthesia	3-9
6. By Report Codes for Professional Services	3-10
7. Bilateral Procedures (Modifier -50)	3-10
8. Reimbursement for Interpretation of Emergency Room X-rays	3-10
9. Provider Reimbursement in Multiple Claims	3-11
10. Valid Modifiers	3-12
11. Acceptable Billing Forms	3-15
12. Global Surgical Care for Professional Services	3-15
13. Clinical Editor	3-16
C. Hospital Services	3-17
1. Eligible Providers	3-17
2. Definitions	3-17
a. Inpatient	3-17
b. Outpatient	3-17
3. Prior Authorization and Additional Information	3-17
a. Inpatient Services	3-17
b. Outpatient Services	3-17
c. Emergency Department	3-18
4. Hospital Inpatient Reimbursement	3-18
a. Overview	3-18
b. Interim Bills	3-18
c. Late Charges	3-18
d. Provider Types Excluded from BWC's Hospital Inpatient Reimbursement Methodology	3-18
e. Appeals	3-18
f. Covered Services	3-18
g. Non-Covered Services	3-18
5. Hospital Outpatient Reimbursement	3-19
6. Billing	3-19
7. Treatment of Unrelated Illness or Injury	3-19
8. Documentation Requirements	3-20
9. Prospective and Retrospective Hospital Bill Reviews	3-20
10. Covered and Non-covered Revenue Center Codes	3-20

11. Revenue Codes Requiring CPT® Codes	3-45
12. Valid Modifier for Hospital Outpatient Services	3-53
D. Ambulatory Surgical Centers	3-55
1. Eligible Providers	3-55
2. Covered Services/Reimbursement	3-55
3. Non-Covered Services	3-55
4. Modifiers	3-55
E. Traumatic Brain Injury	3-57
F. Outpatient Medication Prior Authorization Program	3-58
1. Rules Pertaining to Pharmacy Benefits	3-58
2. Pharmacy Benefits Manager	3-58
3. Prior Authorization	3-58
4. Generic and Brand Name Drugs	3-59
5. Contacts	3-59
6. Injectable and Compounded Medication	3-59
7. Covered Services	3-59
8. Billing	3-60
9. Reimbursement Rates	3-61
10. Supply and Quantity Limits	3-61
11. Forms	3-61
G. Vocational Rehabilitation Services	3-62
1. Eligible Providers	3-62
2. Prior Authorization	3-63
3. Covered Services	3-63
H. Home Health Agency Services	3-86
1. Eligible Providers	3-86
2. Services	3-86
a. Skilled Nursing, Hourly Nursing, Home Health Aid, Social Worker	3-86
b. Mileage and Travel Time	3-86
c. Home Infusion Therapy	3-87
d. Hospice Services	3-87
3. Billing Requirements	3-88
I. Nursing Home Services	3-88
a. Eligible Providers	3-88
b. Services Provided	3-88
c. Billing Requirements	3-88
J. Residential Care/Assisted Living Facilities	3-89
K. TENS and NMES	3-89
1. Required Criteria for TENS/NMES Units	3-89
2. ORC 4123-6-43 Payment for TENS/NMES	3-92
3. Coding and Reimbursement of TENS/NMES	3-93
L. Low Level Laser Therapy	3-93
M. Other BWC Certified Provider Services	3-93
1. Durable Medical Equipment	3-93
2. Equipment used as Part of a Surgical Procedure	3-94
N. Services Approved and Reimbursed by BWC	3-95
1. Caregiver Services	3-95
2. Home and Vehicle Modification	3-95
3. Prosthetics/Artificial Appliances	3-99
4. Interpreter Services	3-99
5. Catastrophic Case Management Plan (previously called Life Care Plan)	3-101
O. Exposure or contact with blood/potentially infectious materials with/without injury	3-102
1. Exposure Claim Processing	3-102
2. SB223 Exposure Claims	3-103
P. Chronic Pain	3-104
1. Drug Screens	3-106
Q. Utilizing Prescription Medication for the Treatment of Intractable Pain	3-108
R. Vertebral Axial Decompression	3-112
S. Interferential Therapy	3-112
T. Smoking Deterrent Programs	3-112
U. ICD-CM Codes for Pain	3-113

A. GENERAL

- Individual providers that are qualified to be enrolled as a BWC provider type must enroll to receive an individual provider number. This individual provider number shall be submitted as the servicing provider number for billing purposes, unless otherwise noted below.
- Providers eligible to provide services for injured workers shall be authorized by law to perform the service(s) being billed and practicing within the scope of his/her practice and/or license.
- **Therapy Visits –**
The maximum time allowable per visit for therapy services with timed procedure codes, i.e., physical medicine and rehabilitation modalities and therapeutic procedures should be no longer than one hour without prior authorization. If therapy services with timed codes are billed over one hour/day, further medical review and approval must occur if services were not authorized prior to payment being made.
- **Maximum Approval period –**
Timelines for approvals of other medical treatments or services with no specified timeframe on the request should be no longer than 30 days. Services not able to be or not rendered in this time must have an update in IW claim notes as to the rationale for the delayed service delivery. Services that run continuously over a longer timeframe (such as facility placement) should not be approved for more than six months maximum.

B. PRACTITIONER SERVICES

The following guidelines are intended to facilitate correct coding and billing processes when used in conjunction with the American Medical Association's (AMA) *Physicians' Current Procedural Terminology* (CPT®) book, AMA's monthly *CPT® Assistant* publication or the Centers for Medicare and Medicaid Services (CMS) Level II dental codes.

1. Covered Medical Service Providers

a. Physician of Record (POR)

- Is the primary attending physician chosen by the injured worker to direct treatment. The POR must be an eligible provider who is a BWC-certified provider. The POR may or may not be an MCO panel provider.
- Injured workers with dates of injury prior to October 20, 1993, may retain a non-certified provider as a POR if such relationship already exists.
- Any request to change a POR must be changed to a BWC-certified provider
 - See 3.b. for how to change a POR
- An injured worker may have only one POR at any given time, even in claims where more than one physician treats the injured worker.
- The MCO may not dispute an injured worker's selection of POR.
- A POR must be:
 - A medical doctor (M.D.);
 - An osteopathic medicine (D.O.);
 - A doctor of mechanotherapy (D.M.T.);
 - A doctor of chiropractic (D.C.);
 - A doctor of podiatry (D.P.M);
 - A doctor of dental surgery (D.D.S); or
 - A licensed psychologist (Ph.D or Psy.D.).

b. Physician Assistant

- Provides services within the scope of the approved supervision agreement with their collaborating or supervising physician(s).
- Reimbursed at eighty-five percent (85%) of fee schedule. The reduction does not apply to supplies provided by the practitioner.
- May function as an assistant in surgery, in which case reimbursement is based on both the assistant surgery modifier and the provider type.
 - For example, if the fee for a procedure is \$1,000.00, then that procedure billed with assistant surgery modifier -80 would pay 20% of \$1,000.00 or \$200.00. Since the Physician Assistant

is reimbursed at 85% of the fee schedule, the fee in this case would be 85% of \$200.00 or \$170.00.

Reimbursement may not be made directly to a Physician Assistant, but to the supervising physician with whom s/he has an approved supervision agreement. All services provided by a physician assistant must be billed to BWC using the physician assistant's BWC issued provider number typed in block 25 of the CMS 1500, as s/he is the servicing provider. The BWC provider number issued to the supervising physician or physician group must be typed in block 33 to reflect the pay-to provider.

c. Advanced Practice Nurse

- Includes Certified Nurse Practitioners and Clinical Nurse Specialists acting within the scope of the standard care arrangement with their collaborating or supervising physician(s).
- Reimbursed at eighty-five percent (85%) of fee schedule. The reduction does not apply to supplies provided by the practitioner.
- Advanced Practice Nurses enrolled with BWC may provide and be reimbursed for assistant in surgery services, in which case reimbursement is based on both the assistant surgery modifier and the provider type.
 - For example, if the fee for a procedure is \$1,000.00, then that procedure billed with assistant surgery modifier -80 would pay 20% of \$1,000.00 or \$200.00. Since the Advanced Practice Nurse is reimbursed at 85% of the fee schedule, the fee in this case would be 85% of \$200.00 or \$170.00.
- Registered Nurse First Assistants in Surgery (CNOR) who are not Advanced Practice Nurses may not be enrolled as BWC providers and may not be reimbursed for assistant surgery services.

d. Independent Social Worker

- Reimbursed at eighty-five percent (85%) of fee schedule.

e. Professional Clinical Counselor

- Reimbursed at eighty-five percent (85%) of fee schedule.

f. Social Worker

- Reimbursed at seventy-five percent (75 %) of fee schedule.

g. Professional Counselor

- Reimbursed at seventy-five (75%) of fee schedule.

h. Physical Therapist, Occupational Therapist, Speech Pathologist and Massage Therapist

- Required to become individually enrolled with BWC if employed by mixed group practices (i.e., MD, DO, DC, APN, PA, PT, etc.).
- Not required to be individually enrolled if employed by therapy groups, home health agencies, skilled nursing facilities, or hospitals.

i. Licensed Athletic Trainers

- Licensed athletic trainers are eligible for enrollment by BWC.
- CPT® codes 97005 and 97006, in addition to other CPT® codes within their scope of practice, may be billed when providing the described services.
- Required to become individually enrolled with BWC if employed by mixed group practices (i.e., MD, DO, DC, APN, PA, PT, etc.).
- Not required to be individually enrolled if employed by therapy groups, home health agencies, skilled nursing facilities, or hospitals.

j. Non-Physician Acupuncturists

- Must have a state medical board certificate of registration.

- These practitioners are reimbursed for acupuncture services only.
- BWC does not reimburse evaluation and management (E&M) codes to acupuncturists.

k. Urgent Care Facility

i.) Free Standing

- Free-standing urgent care facilities must be enrolled as provider type 96.
- A free-standing urgent care facility may bill only for physician services.
- For reimbursement purposes, BWC will treat free-standing urgent care centers as any other physician's clinic.
- BWC will not reimburse free-standing urgent care centers a facility fee.

ii.) Hospital Based

- Must be enrolled as a hospital provider type and will be assigned a separate provider number (see MEDCO-13 form).
- An urgent care facility must be a part of the hospital cost report in order to be reimbursed a facility fee.

l. Ergonomist

- To be BWC certified, an ergonomist must have one of the following certifications:
 - Certified professional ergonomist (CPE);
 - Certified human factors professional (CHFP);
 - Associate ergonomics professional (AEP);
 - Associate human factors professional (AHFP);
 - Certified ergonomics associate (CEA);
 - Certified safety professional (CSP) with ergonomics specialist designation;
 - Certified industrial ergonomist (CIE);
 - Certified industrial hygienist (CIH);
 - Assistive technology practitioner (ATP); or
 - Rehabilitation engineering technologist (RET).
- Ergonomic services must be signed and dated by the actual servicing provider specifying his/her credentials.
- An employer signature is required on the action plan.
- Ergonomists may be reimbursed for travel and mileage. *See* fee schedule for current reimbursement rates.

2. Covered Vocational Rehabilitation Case Management Providers

- To provide and receive payment for vocational rehabilitation case management, including the services provided by an intern, the service provider must be BWC certified and enrolled.
- Rule 4123-6-02.2(C) (44) identifies the type of credentials a vocational/medical case manager must maintain. A nationally recognized accreditation committee must have credentialed the provider in one of the following:
 - Certified Rehabilitation Counselor (CRC);
 - Certified Disability Management Specialist (CDMS);
 - Certified Rehabilitation Registered Nurse (CRRN);
 - Certified Vocational Evaluator (CVE);
 - Certified Occupational Health Nurse (COHN);
 - Certified Case Manager (CCM); or
 - American Board of Vocational Experts (ABVE).

3. Non-covered providers

- a.** Individual providers** who are not directly reimbursable by BWC and who cannot be directly enrolled with BWC. Examples of these providers include, but are not limited to:
- Physician interns

- Psychology interns or psychology assistants
- Out of state providers providing services in a state that does not have an Ohio equivalent licensure requirement;

**These providers are permitted to provide services under the direct supervision (i.e., in the presence) of a provider who is licensed and enrolled by BWC to deliver such services. The licensed provider must bill for the services.

b. Networks acting as a service coordinating entity only and are not meeting qualifications for a provider type recognized by BWC that directly provides goods or medical services to injured workers.

c. Direct manufacturer or supplier of surgical equipment or surgical supplies.

4. Guidelines

a. Provider Signature on Medical Evidence

The following grid identifies provider types whose signature can be accepted on medical evidence.

Provider Signature on Medical Evidence

The following grid identifies provider types whose signature is acceptable on medical evidence.

PROVIDER TYPE				
FORM	Physician of Record (POR) or treating physician which includes the following: <ul style="list-style-type: none"> • Medical doctor (M.D.), • Osteopath (D.O.), • Chiropractor (D.C.), • Dentist (D.D.S.), • Mechanotherapist (D.M.T.), • Podiatrist (D.P.M.), • Psychologist, • Ophthalmologist. 	Advanced Practice Nurse (A.P.N.) which includes the following: <ul style="list-style-type: none"> • Certified Nurse Practitioner (C.N.P.), • Certified Nurse Specialist (C.N.S.), Physician Assistant (P.A.)	Audiologist (A.U.D.) Optometrist (O.D.) Physical Therapist (P.T.) Occupational Therapist (O.T.)	Licensed Social Worker (L.S.W.) Licensed Professional Counselor (L.P.C.) All other non-physician providers
Physician's Report of Work Ability (MEDCO-14)	YES	NO	NO	NO
A MEDCO-14 must be submitted and signed by the POR or treating physician. An A.P.N. and /or P.A. may not sign a MEDCO-14 , as they may not certify disability.				
Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease (C-9)	YES	YES	Medical Services Reimbursement – YES (see exception below) Recommendation for Additional Condition - NO	NO
Exception: C-9s signed by a P.T. or O.T. for therapy services must be accompanied by a prescription from the POR or treating physician, an A.P.N. or P.A.				

ADR Appeal to the MCO Medical Treatment/Service Decision (C-11)	YES	YES	YES	YES
Indicate causality designation and provide signature on (in the “ Treatment info. ” section of the) First Report of an Injury, Occupational Disease or Death (FROI-1)	YES	YES	NO	NO
	NOTE: FROI-1 applications may be filed by anyone, but the causality designation and provider signature in the “ Treatment info. ” section as noted can only to be completed by those providers designated above.			

General Information Regarding Signatures on Medical Evidence:

- An original or stamped signature on an application or medical evidence is acceptable.
- A form with a scanned signature is acceptable, but an electronic signature is not acceptable.
- Medical reports signed by a POR or treating physician’s authorized “scribe/designee” are acceptable. The scribe/designee will:
 - Sign the POR or treating physician’s name.
 - Enters his/her initials next to the POR or treating physician’s name.

b. Change of physicians

- To change a POR, the injured worker must submit written notification to the MCO or self-insuring employer on the *Notice to Change Physician of Record* form (C-23) or equivalent noting the following:
 - Name and address of the new physician;
 - Reason for the requested change; and
 - Injured worker’s signature.
- The *Notice to Change Physician of Record* form (C-23) is located under the Injured Worker section of OhioBWC.com.

c. Two Physicians Treating at the Same Time OAC 4123-6-27

BWC will not approve medical fees for treatment by more than one physician for the same condition over the same period of time, except where a consultant, anesthesiologist, anesthesiologist, or assistant surgeon is required or where the necessity for treatment by a specialist is clearly shown. The MCO, or in self-insuring employers’ claims, the self-insuring employer, must approve an assistant surgeon in advance, except in cases of emergency.

d. Treatment of Family Members [OAC 4123-6-06.2](#)

Except in cases of emergency, BWC will not pay for treatment of an injured worker that is rendered or directly supervised by the injured worker or an immediate family member. Further, the physician of record (POR) may not be the injured worker or an immediate family member. Immediate family members include a spouse, natural or adoptive parent, child or sibling, stepparent, stepchild, stepbrother or stepsister, father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

e. Multiple Visits

Only one Evaluation and Management code may be billed per provider/injured worker/date of service. If the injured worker has more than one claim allowed, the claim involving the primary reason for the evaluation management service should be billed.

A provider may not bill for multiple claims when performing an Evaluation and Management service.

However, if the injured worker has more than one claim allowed involving different parts of the body, it may be appropriate to bill for services in more than one claim.

f. Reimbursement for In-Home Physician Visits and Physician Mobile Office Visits

In-home physician visits (services) shall require prior authorization after the first visit; however, the first and following visits must meet the *Miller* Criteria.

In-home physician visits may be appropriate and should be approved only when the injured worker is homebound and is unable to access outpatient facilities because of sensory impairment, immobility or transportation problems. Examples might include injured workers with catastrophic conditions or those requiring end of life care. Lack of transportation does not constitute a medical reason for approving in-home physician visits.

Prior approval shall be granted by the MCO according to the plan of care and health care needs for the specific injured worker. Reimbursement to physicians will be made using CPT® codes for Home Visits and the level of code must reflect current coding documentation standards for the CPT® level of service. Services rendered must only be those services indicated by the circumstances that are medically necessary.

Mobile van or trailer physician visits or services, when the injured worker walks to the van or trailer, will be reimbursed as a normal office visit according to CPT® levels of service and **will not be eligible for billing as a home visit**. Mobile offices must bill using the appropriate office or other outpatient services CPT® evaluation and management code, with place of service 15 (mobile unit) and will be reimbursed at BWC's Non-Facility Fee.

If a physician chooses to make a home visit to an injured worker who does not meet the criteria for a home visit or when determined by the MCO/BWC not to be medically necessary, the physician may not bill the services as a home visit. If the services are considered medically appropriate and necessary if delivered in a customary office setting, the physician must bill using the appropriate office or other outpatient services CPT® evaluation and management code, with place of service 12 (home) and will be reimbursed at BWC's Facility Fee.

g. Office Based Surgery: BWC follows state licensure requirements for enrollment of providers. BWC/MCOs who have knowledge of a physician or other licensed healthcare provider who may not be in compliance with his/her licensure requirements in regard to office based surgery or other issues, are encouraged to report this information to the Ohio State Medical Board or other appropriate licensing Board.

1) Physicians who perform surgery in their office must follow State Medical Board rules. BWC will reimburse the following Ohio State Medical Board licensed providers that perform surgery in their offices:

- Medical Doctors (M.D.)
- Doctors of Osteopathic Medicine (D.O.)
- Podiatrists (D.P.M.)

2) BWC will reimburse minor office-based procedures done by State of Ohio licensed Advanced Practice Nurses and Physician Assistants acting within the scope of their practice and under the supervision of an Ohio State Medical Board licensed provider.

3) Providers of office surgery are reimbursed according to BWC's provider fee schedule at the Non-Facility Fee rate with an (office) place of service code.

h. Surgical Procedures Performed in the Emergency Department

Effective for bills with date of service 8/1/10 and after, BWC will append modifier -54 to the CPT® code for all professional services billed for major and minor surgical procedures performed with the emergency department place of service (POS 23).

i. Unsupervised Physical Reconditioning Program (OAC 4123-6-07 (B) (5))

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

j. Billing Codes

Professional reimbursement is in accordance to the OAC [4123-6-08](#). Refer to the current fee schedule for reimbursement rates <http://www.ohiobwc.com/provider/services/agreement.asp>.

BWC and MCOs will accept:

- HCPCS level I (CPT®) billing codes as established by the American Medical Association (AMA). Level I codes are descriptive codes for reporting medical services and procedures. Anesthesia CPT® codes (00100-01999) are recognized and required.
- HCPCS level II billing codes as established by the Centers for Medicare & Medicaid Services (CMS). Level II codes are descriptive codes for reporting durable medical equipment, dental, vision and other services.
- HCPCS local level III billing codes are descriptive terms and identifying codes for services and equipment specific to Ohio workers' compensation. Local codes are available through the link in Chapter Two.

k. Telephone Call Codes (99371-99373)

BWC is HIPAA exempt, and will continue to recognize and reimburse the discontinued CPT® codes for telephone calls made by the appropriate provider. Please seek guidance in the [Medical Documentation Policy](#). The new CPT® codes for evaluation and management services provided per telephone will not be reimbursed as it is the position of BWC that an IW should have their care rendered in person.

l. Consultation Codes (CPT® codes 99241-99245 and 99251– 99255)

Effective Jan. 1, 2010, The Centers for Medicare and Medicaid Services (CMS) no longer reimburses for inpatient and outpatient consultation visits. However, to continue to facilitate quality medical care, BWC will continue to recognize and reimburse the current CPT consultation codes noted above.

- 1) Consultative services are distinguished from other E/M codes in that a physician provides his or her opinion regarding the E/M of a specific problem. He or she provides advice after receiving a request to do so. Qualified non-physician practitioners may also provide consultations. Do not report ongoing management following the initial consultation service by the consultant with consultation service codes. Report these services as subsequent visits for the appropriate place of service and level of service.
- 2) Consultations require the following:
 - Referring physician documents a request for an opinion on a specific problem;
 - Consultant opinion rendered and documented;
 - Report back to the requesting physician.

5. Anesthesia

BWC requires anesthesia CPT® codes (00100 - 01999). The fee schedule for CPT® code anesthesia base units is located at <http://www.ohiobwc.com/provider/services/agreement.asp>.

a) General Considerations:

- If multiple procedures are performed, bill only the anesthesia CPT® code of the primary procedure. General anesthesia modifiers -23, -30, -95 or -QX must accompany the anesthesia CPT® code.

- Anesthesia services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services. These services may not be billed separately.
- Evaluation and management codes billed within the surgical follow-up period are not reimbursable. You may not use modifiers -AA and -P1 through -P6 for physical status.
- Anesthesia time begins when the anesthesiologist or anesthetist is in personal attendance at the surgical procedure and ends when the anesthesiologist or anesthetist is no longer in personal attendance. Anesthesia time is measured in minutes.

b) **Billing and Reimbursement**

- MCOs are responsible for adding the anesthesia base unit (ABU) to the anesthesia time prior to submitting a fee bill to BWC for reimbursement. The sum of the ABU and the anesthesia time (in minutes) will be used to calculate reimbursement. The bill for anesthesia services must reflect total minutes in the units column of the bill form.
- BWC reimburses anesthesia services at 199% of Medicare reimbursement.
- Providers may not bill CPT® codes for services other than general anesthesia with general anesthesia modifiers. Bills will be denied with E.O.B. 380: Payment is denied as the anesthesia modifier is not appropriate to be billed with this procedure code.

6. By Report Codes for Professional Services (See Chapter 3, Section E for Vocational Rehabilitation by report codes)

By Report Codes are codes for a procedure or service that is not typically covered and will not routinely be reimbursed. No fee is associated with the procedure or service. Providers should provide information to the MCO to allow appropriate review.

Authorization and payment of By Report codes require an individual analysis by the MCO prior to submission of the request for approval from BWC Medical Policy. MCO analysis includes:

- researching the appropriateness of the code in relation to the service or procedure;
- cost comparisons in order to render high quality, cost-effective medical care.

7. Bilateral Procedures (Modifier -50)

Practitioners must identify bilateral surgical procedures that are performed at the same operative session on one line, using the appropriate CPT® code and adding modifier -50 to identify the second (bilateral) procedure. This modifier pays 150 percent of the total allowed amount for the procedure performed.

Bilateral radiological procedures may be billed by using the appropriate CPT® code on one line with two units of service or left and right modifier on two lines.

8. Reimbursement for Interpretation of Emergency Room X-rays

The MCOs shall reimburse the radiologist/specialist in situations where more than one physician such as the emergency room 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 also reimburse the emergency room (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.

9. Provider Reimbursement in Multiple Claims

a. Evaluation and Management Services

i. General Rule

- 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.

ii. Injured Worker with Multiple Claims

- 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.

iii. Multiple Physicians

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

b. Osteopathic manipulative treatment

i. Administrative Costs

- Additional reimbursement will not be made to cover administrative costs for billing in more than one claim.

ii. Injured Worker with Two Claims

- 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.

iii. Treatment of Body Regions in Injured Worker with Two Claims

- 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.

iv. Injured Worker with More than Two Claims

- Treatment will not be routinely reimbursed in more than two claims
- Osteopathic manipulative treatment billed in more than two claims on the same date of service will be denied.

c. Chiropractic manipulative treatment

i. Administrative Costs

- Additional reimbursement will not be made to cover administrative costs for billing in more than one claim.

ii. Injured Worker with Two Claims

- 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.

iii. Treatment of Spinal Regions in Injured Worker with Two Claims

- 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 extra spinal 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.

iv. Injured Worker with More than Two Claims

- Treatment will not be routinely reimbursed in more than two claims.
- Chiropractic manipulative treatment billed in more than two claims on the same date of service will be denied.

d. **Physical medicine procedures**

- Reimbursement for physical medicine procedures will be at the BWC fee.
- 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
 - 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.

10. Valid Modifiers

BWC recognizes the following modifier codes, applicable to CPT®, HCPCS Level II and Level III codes. Providers may bill any number of modifiers on one line as long as they represent a logical treatment circumstance.

- For example: -26 and -RT on one line is logical: -26 and -TC on one line is not logical. For date specific reimbursement values, refer to provider fee schedule look up, which can be found at OhioBWC.com.

Valid modifiers for the hospital outpatient and ASC setting can be found in their respective sections of this manual.

-22	Unusual procedural services The MCO must require a report when billing this modifier.
-23	Unusual anesthesia
-24	Unrelated evaluation and management by the same physician during a postoperative period
-25	Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure
-26	Professional component
-TC	Technical component

- Add modifier -TC to the procedure code for the basic service when the technical component is the only service provided. If both professional and technical components were provided, use no modifier.
- 30 Anesthesia component (BWC custom modifier)
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;
 - 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.
 - 32 Mandated service
BWC has no mandated CPT® procedure code services at the present time.
 - 50 Bilateral procedures. This modifier pays 150 percent of the total allowed amount for the procedure performed.
 - 51 Multiple procedures
Pricing is based on the determination of 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 will result in a reimbursement reduction of 50%
 - 53 Discontinued procedure Modifier 53 will result in reimbursement reduction of -50% -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
 - 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
 - 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
 - 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
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.).
- RR Rental equipment component reimbursement
- NU New Equipment

a. Level II (HCPCS/National) valid modifiers (with CPT codes only):

- 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
- 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

11. Acceptable Billing Forms

- Practitioners must use either the CMS-1500 or the *Service Invoice* (C-19) form to bill for services.

- On the C-19, “practitioner” must be marked in block 1.
- Practitioners may bill only for treatment of the allowed, compensable condition(s).
- Dentists may also use the American Dental Association billing form.
- For additional billing information, refer to Billing Instructions, Chapter 4.

12. Global Surgical Care for Professional Services

Continuity of care is an important component in the delivery of quality care. Thus, the physician performing surgery is in the best position to continue and/or arrange the coordination of care for the injured worker through all phases of care for the surgical procedure. In those instances when the operating physician is performing pre-operative, intra-operative and post-operative care, a modifier is not required and reimbursement will be 100% of the BWC fee schedule. However, there are legitimate situations when global surgical care is not rendered by the surgeon. The surgical package division percentages are noted in the valid modifiers section.

The total or sum of reimbursement for all services performed in a global surgical care scenario is the same regardless of how the billing is divided between different providers involved in the patient’s care. Correct coding guidelines require that when the components of a global surgical package are performed by different physicians, the same surgical procedure code (with the appropriate modifier) be used by each physician to identify the services provided. The pre-operative service must be billed with the date of service that it was performed. The intra-operative and post-operative services must be billed with the date of the surgery as the date of service. Please note that the post-operative recovery period is 10 days for minor and 60 days for major procedures. Incorrect payment of global surgical services will result in recovery of funds overpaid.

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 the day of 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, incision 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 tracheotomy 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.

Note: Policy Alerts relating to Global Surgical Care topics may be accessed at:
<http://www.ohiobwc.com/provider/services/MCOPolicyGuide.asp#alerts>

13. Clinical Editor

The Bureau of Workers' Compensation utilizes a clinical editing software package from Truven Health Analytics. The software ensures a consistent and well-defined process for reviewing medical billings.

This system does not supplant that of the MCOs. Instead, it is a second level review intended to create a consistent and standardized approach to the screening and reimbursement of provider medical bills.

Truven Health Analytics bases the edits included in the methodology on nationally recognized coding standards and protocols including those from the AMA, American College of Physicians, Journal of the American Medical Association, Federal Register, and the Centers for Medicare and Medicaid Services.

Edit	Description/EOB
Inappropriate assistant surgeon	Identifies procedures that do not warrant payment for an assistant surgeon. EOB 407 – Payment is denied as this procedure does not warrant an assistant surgeon.
Surgical global fee period	Identifies separately billed visits or procedures billed by the operative provider with a related diagnosis that are part of the surgical global fee package. EOB 408 – Payment is denied as this is considered to be part of a global fee.
New patient code frequency	Identifies inappropriately billed new patient codes. EOB 409 – Payment is denied because history shows a previously reimbursed visit with this provider within the past three years and therefore does not meet AMA “new patient” definition.
Post operative care by non-operating provider	Identifies post-operative care provided by a non-operative provider within the same global period of the surgery for a related diagnosis. EOB 410 – Payment is denied as the office/hospital visit falls within the post-surgical follow-up period.
Pre-operative care by non-operating provider	Identifies pre-operative care provided by a non-operative provider within the same global period of the surgery for a related diagnosis. EOB 411 – Payment is denied as the office/hospital visit falls within the pre-operative global period.
Chemistry Lab Unbundled	Identifies line records containing individual lab codes that can be grouped together and paid under a single laboratory panel code. EOB 412 – Payment is denied because the set of

	codes listed should be grouped together under one procedure code as a panel.
--	--

All edits listed above will result in a denial of the billed charge and the provider will be required to resubmit the bill with the appropriate corrections. Providers appealing clinical editing denials must contact the MCO for a bill grievance review. If the MCO written determination continues denial, a provider may file a bill grievance to BWC (See Chapter 1.H.6. for bill grievance process).

C. HOSPITAL SERVICES

1. Eligible Providers

For the purposes of BWC, a hospital is an institution that provides facilities for surgical and medical diagnosis, and treatment of bed patients under the supervision of staff physicians and furnishes twenty-four (24) hour-a-day care by registered nurses. These facilities must be accredited by the Joint Commission or the Health Care Facilities Accreditation Program (HFAP) or the Commission on Accreditation of Rehabilitation Facilities (CARF) for rehabilitation hospitals or approved by the Centers for Medicare and Medicaid Services (CMS) for Medicare participation.

2. Definitions

BWC provides payment for medically necessary covered inpatient and outpatient services provided to injured workers for treatment of allowed compensable condition(s), subject to MCO or SI employer guidelines.

- a. **Inpatient** — [OAC 4123-6-01\(CC\)\(1\)](#); [OAC 4123-6-37.1](#) A patient admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. An injured worker is considered an inpatient if there is a formal order for admission from the physician. The determination of an inpatient stay is not based upon the number of hours involved. If it later develops during the uninterrupted stay that the injured worker is discharged, transferred to another inpatient unit within the hospital, transferred to another hospital, transferred to another state psychiatric facility or expires and does not actually use a bed overnight, the order from the attending physician addressing the type of encounter will define the status of the stay.
- b. **Outpatient** ([OAC 4123-6-01\(CC\)\(2\)](#); [OAC 4123-6-37.2](#))— The injured worker is not receiving inpatient care as defined above, but receives outpatient services at a hospital. An outpatient encounter cannot exceed seventy-two (72) hours of uninterrupted duration.

3. Prior Authorization and Additional Information

a. Inpatient Services

The MCO, or the self-insuring employer in self-insuring employers' claims, is responsible for authorizing and determining medical necessity for all non-emergency inpatient hospital services. The provider of record or treating physician is responsible for contacting the appropriate MCO or self-insuring employer for authorization guidelines. In cases of emergency, prior authorization is not required. The hospital must notify BWC, MCO, QHP, or self-insuring employer within one (1) business day of emergency admission.

b. Outpatient Services

The MCO, or the self-insuring employer in self-insuring employers' claims, is responsible for authorizing and determining medical necessity for all outpatient hospital services. The provider of record or treating physician is responsible for contacting the appropriate MCO or self-insuring employer for authorization guidelines. In cases of emergency, prior authorization is not required.

c. Emergency Department

Treatment in the emergency department of a hospital must be of an immediate nature to constitute an emergency. **Prior authorization of such treatment is not required.** However, in situations where the emergency department is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency department for non-emergent services will not be reimbursed by BWC/MCOs.

4. Hospital Inpatient Reimbursement

a. Overview

BWC 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.

b. Interim Bills

BWC will not process interim bills (bill types 112 and 113) for interim stays of less than thirty (30) days. For a length of stay of thirty (30) days or greater, the initial interim bill submitted will be processed according to the applicable reimbursement methodology. Additional interim bills will be reviewed manually and may result in an adjusted reimbursement amount.

c. Late Charges

Hospital late charges cannot be submitted by providers to MCOs/BWC. Instead, the provider must request adjustment of the initial bill. The provider must include documentation of the hospital's bill for late charges with the adjustment request. This documentation can be hard or soft copy (fax, email) of the UB-04 or the electronic version of the UB-04 (EDI, NSF, etc). All submitted requests shall contain clearly identifiable data elements required for bill processing.

d. Provider Types Excluded from BWC's Hospital Inpatient Reimbursement Methodology

The following provider types are not reimbursed as hospitals by BWC:

- Skilled nursing facilities or units
- Residential care/assisted living facilities

BWC's complete billing guidelines for these provider types are published in Chapter 4 of this manual.

e. Appeals

All appeals regarding hospital inpatient reimbursement must be directed to the appropriate MCO. If the issue is not resolved to the hospital's satisfaction, the hospital may submit a second level of appeal to BWC. Second level appeals should be directed to the BWC Provider Contact Center, Attn: Hospital Appeals at fax # 614-728-9534. 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.

f. Covered Services

Hospital Leave Of Absence - The MCO, or the self-insuring employer, is responsible for authorizing a hospital leave of absence (LOA). 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. The LOA, when prior authorized, shall be billed using revenue center code 183.

g. Non-Covered Services [OAC 4123-6-37](#)

Although the MCO or the self-insuring employer is responsible for authorizing and determining medical necessity for all hospital services, in most cases, BWC will not provide reimbursement for the following items:

a) Convenience Items:

Television, telephone, cosmetics, toiletries or other convenience items, and goods and services requested by the injured worker solely for convenience are not reimbursable. The injured worker should be billed directly for these services.

b) Private Rooms:

Hospitals will be reimbursed at the semi-private room rate. Private rooms are not covered unless the physician justifies that it is medically necessary. Reimbursement may be considered in the following instances:

- The injured worker's condition is such that recovery is jeopardized.
- The injured worker's condition may adversely affect other patients.

Injured workers who request a private room because of convenience may be billed the difference between private and semi-private rates. Injured workers provided private rooms because of the unavailability of semi-private rooms are not to be billed the difference.

5. Hospital Outpatient Reimbursement

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.

6. Billing

To facilitate accurate calculation of reimbursement in the outpatient prospective payment methodology, hospitals should submit all outpatient charges for one date of service or encounter on the same bill.

- a. In most cases, if charges from one date of service or encounter are submitted on separate bills, the first bill will pay and subsequent bills will be denied as potential duplicates.
- b. Exception: Bills containing only therapy charges (e.g. physical, occupational or speech) will not be denied as duplicates if any previously paid bills for the same date of service or date of service range do not contain therapy charges.
- c. Additional charges may be added to a bill that has been paid or is in process. The hospital and MCO should work together to have the original bill adjusted.
- d. Cycle bills are accepted; however BWC will not accept split cycle bills or overlapping dates of service.

All hospital services, billed hardcopy, must be submitted on the UB-04 using revenue center codes. For outpatient hospital services, a number of revenue codes require a corresponding CPT® code. Revenue codes requiring a corresponding CPT® code are noted in this chapter. For outpatient services, a date of service is required on each line of the UB-04 for each service rendered. Lines submitted on outpatient bills with a charge of \$0.00 are accepted and will be priced according to the hospital outpatient prospective payment methodology. Professional services may not be billed on the UB-04.

Hospitals providing these services must obtain a separate BWC provider number for billing purposes and follow specific billing guidelines for each provider type as set forth in the Provider Billing and Reimbursement Manual. For additional enrollment applications, or if you have questions regarding enrollment with BWC, contact Provider Relations at 1-800-OhioBWC.

7. Treatment of Unrelated Illness or Injury

Treatment for unrelated illness or injury, while the injured worker is hospitalized or receiving hospital outpatient services, including Emergency Department services, is not usually reimbursable by BWC. When such unrelated treatment is requested, the requesting physician must identify which services are necessary due to the industrial illness or injury and which are necessary due to the unrelated condition(s). The hospital may be required to remove unrelated charges from the bill.

8. Documentation Requirements

Hospitals must submit documentation to support the diagnosis and procedure codes reported on inpatient and outpatient bills. MCOs are required to validate codes reported by the hospital because coding impacts reimbursement rates.

Documentation for inpatient services may include:

- Admission history and physical
- Emergency department report if applicable
- Operative report if applicable
- Discharge summary and/or progress notes if admission was 48 hours or longer in duration
- Discharge note if admission was less than 48 hours in duration

- Consultations
- Additional documentation may be requested, including but not limited to itemized billing statements, laboratory, radiology and other diagnostic reports

Documentation for outpatient services may include:

- Clinical summary/notes
- Radiology, laboratory, and other diagnostic study reports
- Emergency department reports if applicable
- Operative reports if applicable

9. Prospective and Retrospective Hospital Bill Reviews

Prospective and retrospective reviews will be conducted on hospital bills. Reviews shall include but will not be limited to the following:

- Ensure services are medically necessary for treatment of the allowed claim conditions
- Ensure services are related to allowed claim conditions
- Ensure correct coding
- Identification of billing errors
- Identification of reimbursement errors

Overpayments may be recovered according to the medical overpayment recovery policy.

10. Covered and Non-Covered Revenue Codes

All Inclusive Rate

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
100	All INCL R&B	Covered	Not covered	Not covered
101	All INCL R&B	Covered	Not covered	Not covered

Room and Board-Private Medical or General

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
110	R&B - private	Covered	Not covered	Not covered
111	Medical/Surgical/Gyn	Covered	Not covered	Not covered
112	OB	Not covered	Not covered	Not covered
113	Pediatric	Not covered	Not covered	Not covered
114	Psychiatric	Covered	Not covered	Not covered
115	Hospice	Not covered	Not covered	Not covered
116	Detoxification	Covered	Not covered	Not covered
117	Oncology	Covered	Not covered	Not covered
118	Rehabilitation	Covered	Not covered	Not covered
119	Other	Not covered	Not covered	Not covered

Room & Board-Semi Prvt 2 Bed Medical/General

CODE	DESCRIPTION	Inpatient	Outpatient	Outpatient -
------	-------------	-----------	------------	--------------

			- Dates of service prior to 01/01/2011	Dates of service on or after 01/01/2011
120	R&B semi private 2 bed	Covered	Not covered	Not covered
121	Medical/Surgical/Gyn	Covered	Not covered	Not covered
122	OB	Not covered	Not covered	Not covered
123	Pediatric	Not covered	Not covered	Not covered
124	Psychiatric	Covered	Not covered	Not covered
125	Hospice	Not covered	Not covered	Not covered
126	Detoxification	Covered	Not covered	Not covered
127	Oncology	Covered	Not covered	Not covered
128	Rehabilitation	Covered	Not covered	Not covered
129	Other	Not covered	Not covered	Not covered

Semi-Private-3/4 Beds

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
130	Semi private (3-4 bed)	Covered	Not covered	Not covered
131	Medical/Surgical/Gyn	Covered	Not covered	Not covered
132	OB	Not covered	Not covered	Not covered
133	Pediatric	Not covered	Not covered	Not covered
134	Psychiatric	Covered	Not covered	Not covered
135	Hospice	Not covered	Not covered	Not covered
136	Detoxification	Covered	Not covered	Not covered
137	Oncology	Covered	Not covered	Not covered
138	Rehabilitation	Covered	Not covered	Not covered
139	Other	Not covered	Not covered	Not covered

Private (Deluxe)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
140	Private (deluxe)	Not covered	Not covered	Not covered
141	Medical/Surgical/Gyn	Not covered	Not covered	Not covered
142	OB	Not covered	Not covered	Not covered
143	Pediatric	Not covered	Not covered	Not covered
144	Psychiatric	Not covered	Not covered	Not covered
145	Hospice	Not covered	Not covered	Not covered
146	Detoxification	Not covered	Not covered	Not covered
147	Oncology	Not covered	Not covered	Not covered

148	Rehabilitation	Not covered	Not covered	Not covered
149	Other	Not covered	Not covered	Not covered

Room & Board-Ward

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
150	R&B (ward)	Covered	Not covered	Not covered
151	Medical/Surgical/Gyn	Covered	Not covered	Not covered
152	OB	Not covered	Not covered	Not covered
153	Pediatric	Not covered	Not covered	Not covered
154	Psychiatric	Covered	Not covered	Not covered
155	Hospice	Not covered	Not covered	Not covered
156	Detoxification	Covered	Not covered	Not covered
157	Oncology	Covered	Not covered	Not covered
158	Rehabilitation	Covered	Not covered	Not covered
159	Other	Not covered	Not covered	Not covered

Other Room & Board

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
160	Other R&B (general class)	Not covered	Not covered	Not covered
164	Sterile Environment	Covered	Not covered	Not covered
167	Self Care	Not covered	Not covered	Not covered
169	Other	Not covered	Not covered	Not covered

Nursery

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
170	Nursery	Not covered	Not covered	Not covered
171	Newborn-Level I	Not covered	Not covered	Not covered
172	Newborn-Level II	Not covered	Not covered	Not covered
173	Newborn-Level III	Not covered	Not covered	Not covered
174	Newborn-Level IV	Not covered	Not covered	Not covered
179	Other	Not covered	Not covered	Not covered

Leave of Absence

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
180	Leave of absence	Not covered	Not covered	Not covered
182	Patient Convenience	Not covered	Not covered	Not covered
183	Therapeutic Leave	Covered	Not covered	Not covered
184	ICF/MR -any reason	Not covered	Not covered	Not covered
185	Nursing home	Not covered	Not covered	Not covered
189	Other Leave of absence	Not covered	Not covered	Not covered

Subacute Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
190	Subacute Care	Not covered	Not covered	Not covered
191	Subacute Care Level I	Not covered	Not covered	Not covered
192	Subacute Care Level II	Not covered	Not covered	Not covered
193	Subacute Care Level III	Not covered	Not covered	Not covered
194	Subacute Care Level IV	Not covered	Not covered	Not covered
199	Other Subacute Care	Not covered	Not covered	Not covered

Intensive Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
200	Intensive care	Covered	Not covered	Not covered
201	Surgical	Covered	Not covered	Not covered
202	Medical	Covered	Not covered	Not covered
203	Pediatric	Not covered	Not covered	Not covered
204	Psychiatric	Covered	Not covered	Not covered
206	Intermediate ICU	Covered	Not covered	Not covered
207	Burn Care	Covered	Not covered	Not covered
208	Trauma	Covered	Not covered	Not covered
209	Other Intensive Care	Not covered	Not covered	Not covered

Coronary Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
-------------	--------------------	------------------	--	---

210	Coronary care	Covered	Not covered	Not covered
211	Myocardial Infarction	Covered	Not covered	Not covered
212	Pulmonary Care	Covered	Not covered	Not covered
213	Heart Transplant	Covered	Not covered	Not covered
214	Intermediate CCU	Covered	Not covered	Not covered
219	Other Coronary Care	Not covered	Not covered	Not covered

Special Charges

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
220	Special Charges	Not covered	Not covered	Not covered
221	Admission Charge	Not covered	Not covered	Not covered
222	Technical Support Charge	Not covered	Not covered	Not covered
223	U.R. Service Charge	Not covered	Not covered	Not covered
224	Late Discharge/MED NEC	Not covered	Not covered	Not covered
229	Other special charges	Not covered	Not covered	Not covered

Incremental Nursing Charge Rate

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
230	Incremental NUR charge	Covered	Not covered	Not covered
231	Nursery	Not covered	Not covered	Not covered
232	OB	Not covered	Not covered	Not covered
233	ICU	Covered	Not covered	Not covered
234	CCU	Covered	Not covered	Not covered
235	Hospice	Not covered	Not covered	Not covered
239	Other	Not covered	Not covered	Not covered

All Inclusive Ancillary

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
240	All inclusive ANCIL	Covered	Not covered	Not covered
241	Basic	Not covered	Not covered	Not covered
242	Comprehensive	Not covered	Not covered	Not covered
243	Specialty	Not covered	Not covered	Not covered

249	All INCL ANCIL/OTHER	Not covered	Not covered	Not covered
-----	-------------------------	-------------	-------------	-------------

Pharmacy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
250	Pharmacy	Covered	Covered	Covered
251	Generic Drugs	Covered	Covered	Covered
252	Non-generic Drugs	Covered	Covered	Covered
253	Take Home Drugs	Covered	Covered	Covered
254	Drugs/INCIDENT ODX	Covered	Covered	Covered
255	Drugs/INCIDENT RAD	Covered	Covered	Covered
256	Experimental Drugs	Not covered	Not covered	Not covered
257	Non-prescription	Covered	Covered	Covered
258	IV Solutions	Covered	Covered	Covered
259	Other Pharmacy	Not covered	Not covered	Covered

**IV
Therapy**

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
260	IV Therapy	Covered	Covered	Covered
261	Infusion pump	Covered	Covered	Covered
262	IV THER/PHARM/ SVC	Covered	Covered	Covered
263	IV THER/DRUG/SUPPLY	Covered	Covered	Covered
264	IV THER/SUPPLIES	Covered	Covered	Covered
269	IV Therapy/Other	Not covered	Not covered	Covered

Medical/Surgical Supplies and Devices

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
270	MED-SUR SUPPLIES	Covered	Covered	Covered
271	Non Sterile Supply	Covered	Covered	Covered
272	Sterile supply	Covered	Covered	Covered
273	Take home supplies	Covered	Covered	Covered
274	Prosthetic/Orthotic DV	Covered	Covered	Covered
275	Pace maker	Covered	Covered	Covered

276	Intraocular Lens	Covered	Covered	Covered
277	Oxygen- Take Home	Covered	Covered	Covered
278	Other Implants	Covered	Covered	Covered
279	Other Supplies/Devices	Not covered	Not covered	Covered

Oncology

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
280	Oncology	Covered	Covered	Covered
289	Other oncology	Not covered	Not covered	Covered

Durable Medical Equipment (No Rental)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
290	DME (no rental)	Covered	Covered	Covered
291	Rental	Covered	Covered	Covered
292	Purchase	Covered	Covered	Covered
293	Purchase of used DME	Covered	Covered	Covered
294	Supplies/Drugs for DME effectiveness (HHA only)	Not covered	Not covered	Not covered
299	Other equipment	Not covered	Not covered	Covered

Laboratory

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
300	Laboratory	Covered	Covered	Covered
301	Chemistry	Covered	Covered	Covered
302	Immunology	Covered	Covered	Covered
303	Renal patient (home)	Covered	Covered	Covered
304	Non-routine Dialysis	Covered	Covered	Covered
305	Hematology	Covered	Covered	Covered
306	Bacteriology Microbiology	Covered	Covered	Covered
307	Urology	Covered	Covered	Covered
309	Other laboratory	Not covered	Not covered	Covered

Laboratory Pathological

CODE	DESCRIPTION	Inpatient	Outpatient	Outpatient -
-------------	--------------------	------------------	-------------------	---------------------

			- Dates of service prior to 01/01/2011	Dates of service on or after 01/01/2011
310	Laboratory-Pathology	Covered	Covered	Covered
311	Cytology	Covered	Covered	Covered
312	Histology	Covered	Covered	Covered
314	Biopsy	Covered	Covered	Covered
319	Other	Not covered	Not covered	Covered

Radiology-Diagnostic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
320	Radiology-Diagnostic	Covered	Covered	Covered
321	Angiocardiology	Covered	Covered	Covered
322	Arthrography	Covered	Covered	Covered
323	Arteriography	Covered	Covered	Covered
324	Chest x-ray	Covered	Covered	Covered
329	Other	Not covered	Not covered	Covered

Radiology-Therapeutic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
330	Radiology-Therapeutic	Covered	Covered	Covered
331	Chemotherapy-Injected	Covered	Covered	Covered
332	Chemotherapy-Oral	Covered	Covered	Covered
333	Radiation Therapy	Covered	Covered	Covered
335	Chemotherapy-IV	Covered	Covered	Covered
339	Other	Not covered	Not covered	Covered

Nuclear Medicine

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
340	Nuclear medicine	Covered	Covered	Covered
341	Diagnostic	Covered	Covered	Covered
342	Therapeutic	Covered	Covered	Covered
343	Diagnostic Radiopharmaceuticals	Covered	Covered	Covered

344	Therapeutic Radiopharmaceuticals	Covered	Covered	Covered
349	Other	Not covered	Not covered	Covered

CT Scan

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
350	CT scan	Covered	Covered	Covered
351	Head Scan	Covered	Covered	Covered
352	Body Scan	Covered	Covered	Covered
359	Other CT Scans	Not covered	Not covered	Covered

Operating Room Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
360	Operating Room Services	Covered	Covered	Covered
361	Minor Surgery	Covered	Covered	Covered
362	Organ Transplant (not Kidney)	Covered	Not covered	Not covered
367	Kidney Transplant	Covered	Not covered	Not covered
369	OR/Other	Not covered	Not covered	Covered

Anesthesia

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
370	Anesthesia	Covered	Covered	Covered
371	Incident to Radiology	Covered	Covered	Covered
372	Anesthesia Incident to Other Diagnostic Services	Covered	Covered	Covered
374	Acupuncture	Covered	Covered	Covered
379	Other Anesthesia	Not covered	Not covered	Covered

Blood

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
380	Blood	Covered	Covered	Covered

381	Packed Red Cells	Covered	Covered	Covered
382	Whole Blood	Covered	Covered	Covered
383	Plasma	Covered	Covered	Covered
384	Platelets	Covered	Covered	Covered
385	Leucocytes	Covered	Covered	Covered
386	Other components	Covered	Covered	Covered
387	Other Derivatives	Covered	Covered	Covered
389	Other Blood	Not covered	Not covered	Covered

Blood Storage and Processing

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
390	Blood/Storage/Processing	Covered	Covered	Covered
391	Blood Administration	Covered	Covered	Covered
399	Blood/Other Storage	Not covered	Not covered	Covered

Other Imaging Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
400	Other Imaging Services	Covered	Covered	Covered
401	Diagnostic Mammography	Not covered	Not covered	Not covered
402	Ultrasound	Covered	Covered	Covered
403	Screening Mammography	Not covered	Not covered	Not covered
404	PET Scan	Covered	Covered	Covered
409	Other Imaging Services	Not covered	Not covered	Covered

Respiratory Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
410	Respiratory Services	Covered	Covered	Covered
412	Inhalation Services	Covered	Covered	Covered
413	Hyperbaric O2 Therapy	Covered	Covered	Covered
419	Other RESPIR SVS	Not covered	Not covered	Covered

Physical Therapy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
420	Physical Therapy	Covered	Covered	Covered
421	Visit Charge	Covered	Covered	Covered
422	Hourly Charge	Covered	Covered	Covered
423	Group Rate	Covered	Covered	Covered
424	Evaluation or Re-Eval	Covered	Covered	Covered
429	Other Physical Therapy	Not covered	Not covered	Covered

Occupational Therapy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
430	Occupational Therapy	Covered	Covered	Covered
431	Visit Charge	Covered	Covered	Covered
432	Hourly Charge	Covered	Covered	Covered
433	Group Rate	Covered	Covered	Covered
434	Evaluation or Re-Eval	Covered	Covered	Covered
439	Other Occup Therapy	Not covered	Not covered	Covered

Speech-Language Pathology

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
440	Speech Language Path	Covered	Covered	Covered
441	Speech-Visit charge	Covered	Covered	Covered
442	Speech-Hourly charge	Covered	Covered	Covered
443	Speech-Group rate	Covered	Covered	Covered
444	Speech-Evaluation	Covered	Covered	Covered
449	Other Speech-Language	Not covered	Not covered	Covered

Emergency Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
450	Emergency Room	Covered	Covered	Covered
451	EMTALA Emergency Medical Screening	Not covered	Not covered	Covered

	Services			
452	ER Beyond EMTALA Screening	Not covered	Not covered	Covered
456	Urgent Care	Covered	Covered	Covered
459	Other Emergency Room	Not covered	Not covered	Covered

Pulmonary Function

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
460	Pulmonary Function Diag.	Covered	Covered	Covered
469	Other Pulmonary Function	Not covered	Not covered	Covered

Audiology

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
470	Audiology	Covered	Covered	Covered
471	Diagnostic	Covered	Covered	Covered
472	Treatment	Covered	Covered	Covered
479	Other Audiology	Not covered	Not covered	Covered

Cardiology

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
480	Cardiology	Covered	Covered	Covered
481	Cardiac Cath Lab	Covered	Covered	Covered
482	Stress test	Covered	Covered	Covered
483	Echocardiology	Covered	Covered	Covered
489	Other cardiology	Not covered	Not covered	Covered

Ambulatory Surgical Care

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
490	Ambulatory Surgical Care	Not covered	Not covered	Covered
499	Other Ambulatory Surg.	Not covered	Not covered	Covered

Outpatient Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
500	Outpatient services	Not covered	Not covered	Not covered
509	Other outpatient services	Not covered	Not covered	Not covered

Clinic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
510	Clinic	Covered	Covered	Covered
511	Chronic pain Center	Covered	Covered	Covered
512	Dental Clinic	Covered	Covered	Covered
513	Psychiatric Clinic	Covered	Covered	Covered
514	OB/GYN Clinic	Not covered	Not covered	Not covered
515	Pediatric Clinic	Not covered	Not covered	Not covered
516	Urgent care Clinic	Covered	Covered	Covered
517	Family Practice Clinic	Covered	Covered	Covered
519	Other Clinic	Not covered	Not covered	Covered

Free-Standing Clinic

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
520	Free-Standing Clinic	Not covered	Not covered	Not covered
521	Rural Health-Clinic	Not covered	Not covered	Not covered
522	Rural Health-Home	Not covered	Not covered	Not covered
523	Family Practice Clinic	Not covered	Not covered	Not covered
526	Urgent Care Clinic	Not covered	Not covered	Not covered
529	Other Free Standing Clinic	Not covered	Not covered	Not covered

Osteopathic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
530	Osteopathic Services	Not covered	Not covered	Not covered
531	Osteopathic Therapy	Not covered	Not covered	Not covered

539	Other Osteopathic Services	Not covered	Not covered	Not covered
-----	----------------------------	-------------	-------------	-------------

Ambulance

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
540	Ambulance	Not covered	Not covered	Not covered
541	Supplies	Not covered	Not covered	Not covered
542	Medical Transport	Not covered	Not covered	Not covered
543	Heart Mobile	Not covered	Not covered	Not covered
544	Oxygen	Not covered	Not covered	Not covered
545	Air Ambulance	Not covered	Not covered	Not covered
546	Neonatal	Not covered	Not covered	Not covered
547	Ambulance/pharmacy	Not covered	Not covered	Not covered
548	Ambulance telephone EKG	Not covered	Not covered	Not covered
549	Other ambulance	Not covered	Not covered	Not covered

Skilled Nursing

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
550	Skilled Nursing	Not covered	Not covered	Not covered
551	Visit Charges	Not covered	Not covered	Not covered
552	Hourly Charges	Not covered	Not covered	Not covered
559	Other Skilled Nursing	Not covered	Not covered	Not covered

Medical Social Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
560	Medical Social Services	Not covered	Not covered	Not covered
561	Visit Charges	Not covered	Not covered	Not covered
562	Hourly Charges	Not covered	Not covered	Not covered
569	Other Med/Social Services	Not covered	Not covered	Not covered

Home Health Aide (HH)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of	Outpatient - Dates of
-------------	--------------------	------------------	------------------------------	------------------------------

			service prior to 01/01/2011	service on or after 01/01/2011
570	Home Health Aide	Not covered	Not covered	Not covered
571	Visit Charge	Not covered	Not covered	Not covered
572	Hourly Charge	Not covered	Not covered	Not covered
579	Other HH Aide	Not covered	Not covered	Not covered

Other Visits (Home Health)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
580	Other Visits (HH)	Not covered	Not covered	Not covered
581	Visit Charge	Not covered	Not covered	Not covered
582	Hourly Charge	Not covered	Not covered	Not covered
583	Home Health Assessment	Not covered	Not covered	Not covered
589	Other Home Health Visit	Not covered	Not covered	Not covered

Units of Service (Home Health)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
590	Units of service (HH)	Not covered	Not covered	Not covered
599	Home health other units	Not covered	Not covered	Not covered

Home Health – Oxygen

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
600	Oxygen (HH)	Not covered	Not covered	Not covered
601	O2-state/equip/supply/cont	Not covered	Not covered	Not covered
602	O2 supply under 1 LPM	Not covered	Not covered	Not covered
603	O2 supply over 4 LPM	Not covered	Not covered	Not covered
604	O2 portable add-on	Not covered	Not covered	Not covered
609	Other Oxygen	Not covered	Not covered	Not covered

MRI and MRA

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to	Outpatient - Dates of service on or after
-------------	--------------------	------------------	---	--

			01/01/2011	01/01/2011
610	MRI General	Covered	Covered	Covered
611	MRI Brain	Covered	Covered	Covered
612	MRI Spinal Cord	Covered	Covered	Covered
614	MRI Other	Not covered	Not covered	Covered
615	MRA Head and Neck	Covered	Covered	Covered
616	MRA Lower Extremities	Covered	Covered	Covered
618	MRA Other	Not covered	Not covered	Covered
619	MRT Other	Not covered	Not covered	Covered

Medical Surgical Supplies (Extension of 270)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
621	Supplies Incident to RAD	Covered	Covered	Covered
622	Sup Incident to Other DX	Covered	Covered	Covered
623	Surgical Dressings	Covered	Covered	Covered
624	FDA Investigational DEV	Not covered	Not covered	Not covered

Pharmacy-(Extension of 250)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
631	Single Source Drug	Covered	Covered	Covered
632	Multiple Source Drug	Covered	Covered	Covered
633	Restrictive Prescription	Covered	Covered	Covered
634	EPO less than 10,000	Covered	Covered	Covered
635	EPO 10,000 or more	Covered	Covered	Covered
636	Drugs Require detail coding	Covered	Covered	Covered
637	Self-administered drugs	Not covered	Covered	Covered

Home IV Therapy Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
640	Home IV Therapy Services	Not covered	Not covered	Not covered
641	Nonroutine Nursing central	Not covered	Not covered	Not covered
642	IV Site Care, Central	Not covered	Not covered	Not covered

	Line			
643	IV Start/Chng/Periph	Not covered	Not covered	Not covered
644	Nonroutine Nursing Periph	Not covered	Not covered	Not covered
645	TRNG PT/Caregvr/Centr	Not covered	Not covered	Not covered
646	TRNG DSBLPT/Central	Not covered	Not covered	Not covered
647	TRNG PT/Caregvr/Periph	Not covered	Not covered	Not covered
648	TRNG/DSBLPT/Periph	Not covered	Not covered	Not covered
649	Other IV Therapy Services	Not covered	Not covered	Not covered

Hospice Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
650	Hospice Services	Not covered	Not covered	Not covered
651	Routine Home Care	Not covered	Not covered	Not covered
652	Continuous Home Care	Not covered	Not covered	Not covered
655	Inpatient Respite Care	Not covered	Not covered	Not covered
656	General Inpatient Care	Not covered	Not covered	Not covered
657	Physician Services	Not covered	Not covered	Not covered
658	Hospice Room and Board Nursing Facility	Not covered	Not covered	Not covered
659	Other Hospice	Not covered	Not covered	Not covered

Respite Care (HHA Only)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
660	Respite Care	Not covered	Not covered	Not covered
661	Hourly Charge/Skilled Nsg	Not covered	Not covered	Not covered
662	Hourly Charge/HH aide	Not covered	Not covered	Not covered
663	Daily respite charge	Not covered	Not covered	Not covered
669	Other respite charge	Not covered	Not covered	Not covered

Outpatient Special Residence Charges

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
670	OP SPEC RES	Not covered	Not covered	Not covered

671	Hospital Based	Not covered	Not covered	Not covered
672	Contracted	Not covered	Not covered	Not covered
679	OP SPEC RES/Other	Not covered	Not covered	Not covered

Trauma Response

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
681	Trauma response Level I	Covered	Covered	Covered
682	Trauma response Level II	Covered	Covered	Covered
683	Trauma response Level III	Covered	Covered	Covered
684	Trauma response Level IV	Covered	Covered	Covered
689	Other trauma response	Not covered	Not covered	Covered

Cast Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
700	Cast Room	Covered	Covered	Covered
709	Other Cast Room	Not covered	Not covered	Covered

Recovery Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
710	Recovery room	Covered	Covered	Covered
719	Other recovery room	Not covered	Not covered	Not covered

Labor Room/Delivery

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
720	Labor Room/Delivery	Not covered	Not covered	Not covered
721	Labor	Not covered	Not covered	Not covered
722	Delivery	Not covered	Not covered	Not covered
723	Circumcision	Not covered	Not covered	Not covered
724	Birth Center	Not covered	Not covered	Not covered
729	Other Labor room/delivery	Not covered	Not covered	Not covered

EKG/ECG (Electrocardiogram)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
730	EKG/ECG	Covered	Covered	Covered
731	Holter Monitor	Covered	Covered	Covered
732	Telemetry	Covered	Covered	Covered
739	Other EKG/ECG	Not covered	Not covered	Covered

EEG (Electroencepalogram)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
740	EEG	Covered	Covered	Covered
749	Other EEG	Not covered	Not covered	Covered

Gastro Intestinal Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
750	Gastro Intestinal Services	Covered	Covered	Covered
759	Other Gastro-Intestinal	Not covered	Not covered	Covered

Treatment/Observation Room

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
760	Treatment/Observation	Not covered	Not covered	Covered
761	Treatment Room	Covered	Covered	Covered
762	Observation Room	Covered	Covered	Covered
769	Other Treatment or Observation Room	Not covered	Not covered	Covered

Preventive Care Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
-------------	--------------------	------------------	--	---

770	Prevent Care Services	Not covered	Not covered	Not covered
771	Vaccine Administration	Not covered	Not covered	Not covered
779	Other Preventive	Not covered	Not covered	Not covered

Telemedicine

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
780	Telemedicine	Not covered	Not covered	Not covered
789	Other Telemedicine	Not covered	Not covered	Not covered

Lithotripsy

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
790	Lithotripsy General Class	Covered	Covered	Covered
799	Lithotripsy Other	Not covered	Not covered	Covered

Inpatient Renal Dialysis

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
800	Inpatient Renal Dialysis	Covered	Not covered	Not covered
801	Inpatient Hemodialysis	Covered	Not covered	Not covered
802	IP Peritoneal (Non-CAPD)	Covered	Not covered	Not covered
803	Inpatient CAPD	Covered	Not covered	Not covered
804	Inpatient CCPD	Covered	Not covered	Not covered
809	Other Inpatient Dialysis	Not covered	Not covered	Not covered

Organ Acquisition

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
810	Organ Acquisition	Covered	Not covered	Covered
811	Living Donor	Covered	Not covered	Covered
812	Cadaver Donor	Covered	Not covered	Covered
813	Unknown donor	Covered	Not covered	Covered
814	Unsuccessful Search	Covered	Covered	Covered

819	Other Donor	Not covered	Not covered	Covered
-----	-------------	-------------	-------------	---------

Hemodialysis (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
820	Hemodialysis (op/home)	Not covered	Covered	Covered
821	Hemo/Composite	Not covered	Covered	Covered
822	Home Supplies	Not covered	Covered	Covered
823	Home Equipment	Not covered	Covered	Covered
824	Maintenance / 100%	Not covered	Covered	Covered
825	Support Services	Not covered	Covered	Covered
829	Other Outpatient Hemo	Not covered	Not covered	Covered

Peritoneal Dialysis (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
830	Peritoneal Dialysis (OP)	Not covered	Covered	Covered
831	Peritoneal/Composite	Not covered	Covered	Covered
832	Home Supplies	Not covered	Covered	Covered
833	Home Equipment	Not covered	Covered	Covered
834	Maintenance / 100%	Not covered	Covered	Covered
835	Support Services	Not covered	Covered	Covered
839	Other Peritoneal Dialysis	Not covered	Not covered	Covered

CAPD (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
840	CAPD (OP)	Not covered	Covered	Covered
841	CAPD-composite	Not covered	Covered	Covered
842	Home Supplies	Not covered	Covered	Covered
843	Home Equipment	Not covered	Covered	Covered
844	Maintenance / 100%	Not covered	Covered	Covered
845	Support Services	Not covered	Covered	Covered
849	Other OP CAPD	Not covered	Not covered	Covered

CCPD (Outpatient or Home)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of	Outpatient - Dates of
-------------	--------------------	------------------	------------------------------	------------------------------

			service prior to 01/01/2011	service on or after 01/01/2011
850	CCPD, general class	Not covered	Covered	Covered
851	CCPD, composite	Not covered	Covered	Covered
852	Home Supplies	Not covered	Covered	Covered
853	Home Equipment	Not covered	Covered	Covered
854	Maintenance / 100%	Not covered	Covered	Covered
855	Support Services	Not covered	Covered	Covered
859	Other Outpatient CCPD	Not covered	Not covered	Covered

Miscellaneous Dialysis

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
880	Miscellaneous Dialysis	Covered	Covered	Covered
881	Ultrafiltration	Covered	Covered	Covered
882	Home Dialysis Aid Visit	Not covered	Covered	Covered
889	Misc. Dialysis Other	Not covered	Not covered	Covered

Behavioral Health Treatments/Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
900	Psychiatric/Psychological Treatments	Not covered	Not covered	Covered
901	Electroshock Treatments	Not covered	Not covered	Covered
902	Milieu Therapy	Not covered	Not covered	Not covered
903	Play Therapy	Not covered	Not covered	Not covered
904	Activity Therapy	Not covered	Not covered	Not covered
905	Intensive Outpatient Services Psychiatric	Not covered	Covered	Covered
906	Intensive Outpatient Services Chemical Dependency	Not covered	Covered	Covered
907	Community Behavioral Health Program Day Treatment	Not covered	Not covered	Covered

Behavioral Health Treatments/Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
-------------	--------------------	------------------	--	---

910	Psychiatric/Psychological	Covered	Covered	Covered
911	Rehabilitation	Covered	Covered	Covered
912	Partial Hospitalization less Intensive	Covered	Covered	Covered
913	Partial Hospitalization Intensive	Covered	Covered	Covered
914	Individual Therapy	Covered	Covered	Covered
915	Group Therapy	Covered	Covered	Covered
916	Family Therapy	Covered	Covered	Covered
917	Bio Feedback	Covered	Covered	Covered
918	Testing	Covered	Covered	Covered
919	Other	Not covered	Not covered	Covered

Other Diagnostic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
920	Other Diagnostic Services	Covered	Covered	Covered
921	Peripheral Vascular Lab	Covered	Covered	Covered
922	Electromyelogram	Covered	Covered	Covered
923	Pap Smear	Covered	Covered	Covered
924	Allergy Test	Covered	Covered	Covered
925	Pregnancy Test	Covered	Covered	Covered
929	Other Diagnostic Services	Not covered	Not covered	Covered

Medical Rehabilitation Day Program

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
931	Half day	Not covered	Not covered	Not covered
932	Full day	Not covered	Not covered	Not covered

Other Therapeutic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
940	Other Therapeutic Services	Covered	Covered	Covered
941	Recreational Therapy	Covered	Covered	Covered
942	Education/Training	Covered	Covered	Covered

943	Cardiac Rehab	Covered	Covered	Covered
944	Drug Rehab	Covered	Covered	Covered
945	Alcohol Rehab	Covered	Covered	Covered
946	Complex Med Equip- Rout	Covered	Covered	Covered
947	Complex Med Equip- Anc	Covered	Covered	Covered
949	Other Therapeutic Services	Not covered	Not covered	Covered

Other Therapeutic Services

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
952	Kinesiotherapy	Not covered	Not covered	Not covered

Professional Fees

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
960	Professional Fees	Not covered	Not covered	Not covered
961	Psychiatric	Not covered	Not covered	Not covered
962	Ophthalmology	Not covered	Not covered	Not covered
963	Anesthesiologist (MD)	Not covered	Not covered	Not covered
964	Anesthetist (CRNA)	Not covered	Not covered	Not covered
969	Other Professional Fees	Not covered	Not covered	Not covered

Professional Fees (Extension of 960)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
971	Laboratory	Not covered	Not covered	Not covered
972	Radiology-Diagnostic	Not covered	Not covered	Not covered
973	Radiology-Therapeutic	Not covered	Not covered	Not covered
974	Radiology-NUC MED	Not covered	Not covered	Not covered
975	Operating Room	Not covered	Not covered	Not covered
976	Respiratory Therapy	Not covered	Not covered	Not covered
977	Physical Therapy	Not covered	Not covered	Not covered
978	Occupational Therapy	Not covered	Not covered	Not covered
979	Speech Pathology	Not covered	Not covered	Not covered

Professional Fees (Extension of 960 & 970)

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
981	Emergency Room	Not covered	Not covered	Not covered
982	Outpatient Services	Not covered	Not covered	Not covered
983	Clinic	Not covered	Not covered	Not covered
984	Medical Social Services	Not covered	Not covered	Not covered
985	EKG	Not covered	Not covered	Not covered
986	EEG	Not covered	Not covered	Not covered
987	Hospital Visit	Not covered	Not covered	Not covered
988	Consultation	Not covered	Not covered	Not covered
989	Private Duty Nurse	Not covered	Not covered	Not covered

Patient Convenience Items

CODE	DESCRIPTION	Inpatient	Outpatient - Dates of service prior to 01/01/2011	Outpatient - Dates of service on or after 01/01/2011
990	Patient convenience Items	Not covered	Not covered	Not covered
991	Cafeteria/Guest Tray	Not covered	Not covered	Not covered
992	Private Linen Service	Not covered	Not covered	Not covered
993	Telephone/Telegraph	Not covered	Not covered	Not covered
994	TV/Radio	Not covered	Not covered	Not covered
995	Nonpatient Room Rentals	Not covered	Not covered	Not covered
996	Late Discharge Charge	Not covered	Not covered	Not covered
997	Admission Kits	Not covered	Not covered	Not covered
998	Beauty Shop/Barber	Not covered	Not covered	Not covered
999	Other PT Convenience	Not covered	Not covered	Not covered

11. Revenue Codes Requiring CPT® Codes for Hospital Outpatient Services

IV Therapy

CODE	Revenue Center Description
261	Infusion Pump

Items Medical/Surgical Supplies and Devices (see also 062X)

CODE	Revenue Center Description
-------------	-----------------------------------

274	Prosthetic/orthotic devices
-----	-----------------------------

Laboratory

CODE	Revenue Center Description
300	Laboratory - General
301	Chemistry
302	Immunology
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology & Microbiology
307	Urology
309	Other laboratory

Laboratory Pathological

CODE	Revenue Center Description
310	Laboratory Pathological - Gen
311	Cytology
312	Histology
314	Biopsy
319	Other laboratory pathology

Radiology Diagnostic

CODE	Revenue Center Description
320	Radiology Diagnostic - General
321	Angiocardiology
322	Arthrography
323	Arteriography
324	Chest X-ray
329	Other Radiology Diagnostic

Radiology Therapeutic

CODE	Revenue Center Description
330	Radiology Therapeutic - General
331	Chemotherapy

* Not required by Medicare under OPSS. Required by BWC.

	injected
332	Chemotherapy oral
333	Radiation therapy
335	Chemotherapy IV
339	Other Radiology Therapeutic

* Not required by Medicare under OPSS. Required by BWC.

Nuclear Medicine

CODE	Revenue Center Description
340	Nuclear Medicine - General
341	Diagnostic
342	Therapeutic
343	Diagnostic radiopharmaceuticals
344	Therapeutic radiopharmaceuticals
349	Other Nuclear Medicine

CT Scan

CODE	Revenue Center Description
350	CT Scan - General
351	CT Scan-head
352	CT Scan-body
359	Other CT scans

Operating Room Services

CODE	Revenue Center Description
360	Operating Room Services-General
361	Minor Surgery
369	Other OR services

Blood and Blood Components

CODE	Revenue Center Description
380	General
381	Packed Red Cells

382	Whole blood
383	Plasma
384	Platelets
385	Leukocytes
386	Other components
387	Other derivatives
389	Other blood

Administration, Processing and Storage for Blood and Blood Components

391	Administration
-----	----------------

Other Imaging Services

CODE	Revenue Center Description
400	Other Imaging services - General
401	Diagnostic mammography
402	Ultrasound
403	Screening mammography
404	PET Scan
409	Other Imaging services

* Not required by Medicare under OPSS. Required by BWC.

Respiratory Services

CODE	Revenue Center Description
410	Respiratory Serv-General
412	Inhalation Services
413	Hyperbaric oxygen
419	Other Respiratory services

Physical Therapy

CODE	Revenue Center Description
420	Physical Therapy -

	General
421	PT-Visit charge
422	PT-Hourly charge
423	PT-Group rate
424	PT-Evaluation
429	Other Physical Therapy

Occupational Therapy

CODE	Revenue Center Description
430	Occupational Therapy - General
431	OT-Visit charge
432	OT-Hourly charge
433	OT-Group rate
434	OT-Evaluation or re-evaluation
439	OT-Other occupational therapy (may include restorative therapy)

Speech Therapy

CODE	Revenue Center Description
440	Speech Pathology - General
441	Speech-Visit charge
442	Speech-Hourly charge
443	Speech-Group rate
444	Speech-Evaluation or re-evaluation
449	Other speech-language pathology

Emergency Room Services

CODE	Revenue Center Description
-------------	-----------------------------------

450	Emergency Room
451	EMTALA emergency medical screening services
452	ER beyond EMTALA screening
456	Urgent Care
459	Other ER

Pulmonary Function

CODE	Revenue Center Description
460	Pulmonary Function - General
469	Other Pulmonary Function

Audiology

CODE	Revenue Center Description
470	Audiology - General
471	Audiology - Diagnostic
472	Audiology - Treatment
479	Other Audiology

Cardiology

CODE	Revenue Center Description
480	Cardiology - General
481	Cardiology - Cardiac Cath Lab
482	Cardiology - Stress Test
483	Cardiology - Echocardiology
489	Other Cardiology

Ambulatory Surgical Care

CODE	Revenue Center Description
490	Ambulatory Surgical Care - General
499	Other Ambulatory Surgical Care

Clinic

CODE	Revenue Center Description
510	Clinic - General

511	Chronic Pain Center
512	Dental Clinic
513	Psychiatric Clinic
516	Urgent Care Clinic
517	Family Practice Clinic
519	Other Clinic

Magnetic Resonance Imaging

CODE	Revenue Center Description
610	Magnetic Resonance Imaging
611	MRI-Brain
612	MRI-Spinal Cord
614	MRI- Other
615	MRI-Head and Neck
616	MRI-Lower Extremities
618	MRA-Other
619	Other MRT

Medical/Surgical Supplies Extension of 27X

CODE	Revenue Center Description
623	Surgical dressings

Pharmacy-Extension of 25X

CODE	Revenue Center Description
636	Drugs requiring detailed coding
637	Self-Administrable Drugs

EKG/ECG (Electrocardiogram)

CODE	Revenue Center Description
730	EKG/ECG - General
731	Holter monitor
739	Other EKG/ECG

* Not required by Medicare under OPSS. Required by BWC.

EEG (Electroencephalogram)

CODE	Revenue Center Description
740	EEG - General
749	Other EEG

Gastrointestinal Services

CODE	Revenue Center Description
750	Gastrointestinal Services - Gen
759	Other General Gastrointestinal Services

Treatment and Observation Room

CODE	Revenue Center Description
761	Treatment Room
769	Other Treatment/Observation

Extra-Corporeal Shock Wave Therapy- formerly Lithotripsy

CODE	Revenue Center Description
790	Extra-Corporeal Shock Wave Therapy
799	Extra-Corporeal Shock Wave Therapy-Other

Acquisition of Body Components

CODE	Revenue Center Description
810	Organ Acquisition
811	Acquisition of body components-living donor
812	Acquisition of body components-cadaver donor
813	Acquisition of body components-unknown donor
814	Donor bank charges for an unsuccessful search
819	Other Donor

* Not required by Medicare under OPPS. Required by BWC.

* Not required by Medicare under OPPS. Required by BWC.

Behavioral Health Treatments/Services

CODE	Revenue Center Description
900	Psychiatric Services - General
901	Electroshock

	Treatment
902	Milieu therapy
903	Play therapy
904	Activity therapy
907	Community behavior health program-day treatment

* Not recognized by Medicare under OPPTS. Recognized by BWC.

**Behavioral Health Treatments/Services-
Extension of 90X**

CODE	Revenue Center Description
911	Psych - Rehab
914	Psych - Indiv Therapy
915	Psych - Group Therapy
916	Psych - Family Therapy
917	Biofeedback
918	Psych - Testing
919	Other Behavioral health treatments

Other Diagnostic Services

CODE	Revenue Center Description
920	Other Diagnostic Services - Gen
921	Peripheral Vasc Lab
922	Electromyelogram
924	Allergy Test
929	Other Diagnostic Services

Other therapeutic services

CODE	Revenue Center Description
941	Recreational Therapy
943	Cardiac Rehab
949	Other therapeutic services -

Other therapeutic services

CODE	Revenue Center Description
951	Athletic training
952	Kinesiotherapy

12. Valid Modifiers for Hospital Outpatient Services

Modifier	Description
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
27	Multiple outpatient hospital E/M encounters on the same date.
50	Bilateral procedure
52	Reduced services
58	Staged or related procedure or service by the same physician during the postoperative period
59	Distinct procedural service
73	Discontinued outpatient hospital/ambulatory surgery center procedure prior to the administration on anesthesia
74	Discontinued outpatient hospital/ambulatory surgery center procedure after the administration on anesthesia
76	Repeat procedure or service by same physician
77	Repeat procedure by another physician
78	Unplanned return to the operating/procedure room by the same physician following initial procedures for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician during the postoperative period
91	Repeat clinical diagnostic laboratory test
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
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
GN	OP speech language service
GO	OP occupational therapy service
GP	OP physical therapy services
LC	Left circumflex coronary artery
LD	Left descending coronary artery
LT	Left side
RC	Right coronary artery
RT	Right side
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

D. AMBULATORY SURGICAL CENTER

1. Eligible Providers

Ambulatory surgical centers (ASCs) must be certified for Medicare participation by their state's Department of Health in order to be eligible to provide services to Ohio's injured workers. CMS certifies ASC Facilities that are qualified to provide services and reimbursement for Medicare covered procedures. BWC will continue to follow CMS requirements and definition of an ASC.

- A facility licensed by the Ohio Department of Health (ODH) as an Ambulatory surgery facility (ASF) does not receive Medicare reimbursement. BWC will not enroll an ASF in a separate category of service and are will not reimburse ASFs.

2. Covered Services/Reimbursement

- BWC reimburses ASCs using a modified version of Medicare’s ASC prospective reimbursement system. The modifications adopted by BWC are specified in Ohio Administrative Code [4123-6-37.3](#) and [Fee Schedule](#). To view the current and previous ASC reimbursement rules go to www.ohiobwc.com.
- Bills shall be submitted on a CMS-1500 or BWC C-19 Service Invoice.
- Services for which payment is packaged into the reimbursement of the surgical procedure include, but are not limited to:
 - Nursing, technician and related services;
 - Use of the facility where the procedure is performed;
 - Drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances and equipment directly related to the provision of the surgical procedures for which separate payment is not allowed;
 - Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
 - Administrative or record keeping items and services; and
 - Materials used for anesthesia.

3. Non-Covered Services

Reimbursement for items and services not included as ASC facility services must be billed separately, not by the ASC. These items and services include:

- Physician services.
- Prosthetic and orthotic devices;
- DME for use in the injured worker’s home.

4. Modifiers

The following HCPCS Level I and II modifiers are accepted.

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	59 – Distinct procedural service
F6 – right hand, second digit	73 – Discontinued outpatient
F7 – right hand, third digit	hospital/ASC procedure prior to the
F8 – right hand, fourth digit	administration of anesthesia
F9 – right hand, fifth digit	74 – Discontinued outpatient
	hospital/ASC procedure after
	administration of anesthesia
	76 – repeat procedure or service by

same physician

77 – repeat procedure by another
physician
91 – repeat clinical diagnostic
laboratory test

Modifier Reporting Examples

The following examples are provided to assist ASCs in correctly reporting services:

Bilateral Procedures

Bilateral procedures should be reported with modifier -50.

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

Below are two examples of the correct reporting for multi-level spinal procedures.

Example: Lumbar transforaminal epidural injections are administered at L1, L2 and L3. The correct way to bill these procedures 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 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

Below are two examples of the correct reporting for a multiple tendons, ligaments, muscles or joints procedures that are described by CPT® as each tendon or each joint.

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.

E. TRAUMATIC BRAIN INJURY (TBI)

TBI is an injury to the head arising from a blunt or penetrating trauma or from acceleration or deceleration forces. That result in:

1. Mild TBI that is manifested by at least one of the following:

- Any alteration in mental state at the time of the accident (e.g., transient confusion, disorientation, impaired consciousness); and/or
- Focal neurological deficit(s) that may be transient, and show no evidence of traumatically induced intracranial lesion on neuroimaging studies.

2. Moderate/severe TBI that is manifested by at least one of the following:

- Loss of consciousness (LOC) greater than 30 minutes;
- Post traumatic amnesia (PTA) greater than 24 hours; and/or
- Evidence of traumatically induced intracranial lesion on neuroimaging studies.

TBI facilities

Admission into a TBI facility requires an assessment that demonstrates the injured workers current level of function and need for the particular facility. Thereafter, monthly documentation of care provided (i.e., comprehensive reports) must be submitted for injured workers in acute and post-acute facilities and quarterly reports are required for injured workers in lifelong or transitional living facilities. All placement approval and service levels (as defined below) require prior authorization from the MCO. Reports must be submitted to the MCO and include the following:

- Treatment history and expected discharge outcomes, to include discharge date and discharge placement goals;
- Disciplines involved in the treatment team and the number of hours the injured worker spends with the treatment team members;
- Status of treatment goals;
- Treatment progress summary and comparison/progress from previous reports.
- Medical summary including neurological and cognitive functioning assessment/scale (e.g., Ranchos Los Amigos or Glasgow scale), medical problems and how these relate to treatment; and,
- Family interactions.

Types of TBI facilities include:

- **Acute Brain Injury Facility:** provides freestanding (W0177) or hospital- based (W0178) acute care focusing on intensive physical and cognitive restorative services for brain-injured individuals.
- **Post-Acute Brain Injury Facility:** provides freestanding (W0179) or hospital-based (W0181) post-acute care serving injured workers who no longer require an acute comprehensive inpatient rehabilitation program, but demonstrate the need for rehabilitation and specialized services. Services provided in an acute brain injury facility are directed toward the development of the most optimal level of independent functioning. This level of care is not expected to have longer than a 12-18 month duration.
- **Transitional Living Placement Facility (W0185):** provides short-term reintegration services for the injured worker to transition into the community and may follow an acute or post-acute program model. These facilities may provide occupational therapy (OT), physical therapy (PT), speech therapy, job coaching, job development, and job placement as appropriate for the injured worker.
- **Lifelong Living TBI Facility (W0182):** provides post acute or lifelong living services for an injured worker who is not able to return independently to the workforce and/or community.

F. OUTPATIENT MEDICATION PRIOR AUTHORIZATION PROGRAM

1. Rules pertaining to Pharmacy Benefits

[OAC 4123-6-21](#) - Payment for outpatient medication

OAC [4123-6-21.1](#) - Payment for outpatient medication by self-insuring employer

OAC [4123-6-21.2](#) - Pharmacy and therapeutics committee

OAC 4123-6-21.3 - Outpatient medication formulary

OAC 4123-6-21.3- [Outpatient medication formulary Appendix A](#)

[OAC 4123-6-21.4](#) – Coordinated services program

2. Pharmacy Benefits Manager

Catamaran is BWC's Pharmacy Benefits Manager (PBM). The PBM processes outpatient medication bills for State-Fund, Black Lung and Marine Industrial Fund claims. The PBM is a single source for accepting and adjudicating prescription drug information and is separate from the Managed Care Organizations (MCOs). This program does not apply to claims managed by self-insured employers. Questions related to self-insured claims should be referred to the injured worker's employer.

As part of its responsibilities, the PBM:

- Performs on-line, point-of-service adjudication of outpatient medication bills with prescription information transmitted electronically between a pharmacy and PBM;
- Enrolls pharmacy providers in a BWC-specific network;
- Maintains a prior authorization (PA) system for certain outpatient medications identified by BWC and
- Utilizes review editing for prescribed medications.

3. Prior Authorization

BWC requires injured workers to get prior authorization for certain drugs not typically used to treat work-related injuries or illnesses (when there is not an allowed condition in the claim that is included among the FDA-approved uses of the prescribed drug). The PBM processes prior authorization requests. The prescribing physician is required to complete the *Request for Prior Authorization of Medication Form* (MEDCO-31) to document the relationship between the prescribed drug and the allowed condition(s) in an injured worker's claim. In surgical situations where medications are needed but are denied in the claim, the request form can be submitted to the PBM prior to the scheduled surgery and an authorization can be granted with a thirty (30) day fill limit. The Prior Authorization Medication List and Form may be accessed through <http://www.ohiobwc.com> under Medical Provider and then Services, or call 1-800-OHIOBWC, and follow the prompts. If you have questions related to a self-insured claim, please contact the employer. Injured workers with self-insured claims should have cards with employer contact information.

BWC requires prior authorization for all medications in Medical only claims beyond 60 days from the date of injury.

Prior to a BWC approved scheduled surgery, the physician can submit a MEDCO31 Prior Authorization Request form to the PBM and include the specific date of the surgery for consideration. Additionally, the form can also be used to request pain medication or other post-surgically related medications that may be needed which are denied in the claim, a thirty (30) day fill limit would apply.

4. Generic and Brand Name Drugs

Injured workers who request a brand name drug for a medication which has an applicable maximum allowable cost (MAC) price shall have, the following options available:

- The physician agrees that a generic drug may be dispensed
- The physician prescribes a different drug
- The brand name drug is dispensed and the injured worker pays the difference in price between the generic MAC price and the brand name drug requested.

Even if the physician writes “dispense as written” or “DAW” on the prescription, or otherwise indicates that the brand name form of the prescribed drug is “medically necessary”, the injured worker will be responsible for the cost difference between the established maximum allowable cost price of the drug product and the average wholesale price plus or minus the bureau established percentage of the dispensed brand name drug.

5. Contacts

Catamaran: BWC’s PBM is prepared to answer inquiries from injured workers and employers regarding the Outpatient Medication Prior Authorization Program. To contact SXC, call **1-800-OHIOBWC**, and follow the prompts.

BWC Pharmacy Department: Providers, injured workers, employers and their representatives may send questions or comments about pharmacy benefits to BWC’s Pharmacy Department at Pharmacy.Benefits@bwc.state.oh.us or by mail to: Ohio Bureau of Workers’ Compensation, Pharmacy Department, 30 W. Spring St. , L-21, Columbus, OH 43215-2256.

MCOs: Since BWC’s PBM does not reimburse for durable medical equipment or medical supplies purchased at a pharmacy, the injured worker’s MCO needs to be contacted regarding these services. To contact the correct MCO using the injured worker’s claim number, contact a BWC Call Center Agent at 1-800-OHIOBWC or log on to ohiobwc.com, select Medical Providers and then Services.

6. Injectable and Compounded Medication

All outpatient injectable and compoundable medications shall be obtained from a pharmacy and electronically billed by the pharmacy to the PBM. Physicians are permitted to administer outpatient injectable medications but BWC will only reimburse a pharmacy for the medication injected. The physician may bill for the administration of the medication to the MCO but shall not bill for the medication.

A compounded drug is a blend of drugs combined (compounded) by a pharmacist or physician. These medications contain pharmaceuticals in dosage forms and combinations that are not commercially available. Compounded medications do not have a National Drug Code (NDC) number, an average sale price or an average wholesale price.

All compounded medications require prior authorization via the Medco-31 form which is submitted to the PBM.

7. Covered Services

Medications must be prescribed by the treating physician or physician of record (POR) to the industrial claim. FDA-approved legend and over-the-counter (OTC) drugs prescribed by the POR for an allowed compensable injury or disease are reimbursable by BWC. BWC will also reimburse medication prescribed for the treatment of an allowed compensable injury or occupational disease if the medicine prescribed is approved or widely accepted as a treatment for the allowed condition. The pharmacist or supplying physician may verify the allowed conditions in a claim by logging on to www.ohiobwc.com or by calling 1-800-OHIOBWC (1-800-644-6292).

8. Billing

Existing Claims

Pharmacy providers are expected to submit bills for outpatient medications at the point-of-service in all claims, including situations prior to a BWC claim number being assigned. In order to submit a bill at the point-of-service, the pharmacist must transmit at least two of the following three items, along with the other billing information, to the PBM:

- BWC claim number;
- Social Security number;
- Date of injury.

All bills are paid according to the BWC fee schedule. Therefore, when the injured worker has paid for the prescription in full (i.e., an amount greater than the fee schedule) and then seeks reimbursement, the injured worker is responsible for the difference between the price paid and the fee schedule amount. It is in the best interest of the injured worker for the pharmacy to submit the bill(s) for outpatient medication to the PBM electronically.

New Claims - Captured/Suspended Bills

If there is no claim found in the eligibility file that matches the submitted eligibility data elements, or the matched claim is not in a “pending” claim status, the PBM will reject the bill and return a message to the pharmacist that indicates the current claim status and also the amount that would be allowed per BWC’s fee schedule should the medication be allowed. At this point, the pharmacist has 2 options:

1) Accept assignment

At the pharmacist’s discretion, they can elect to “accept assignment” and not charge the alleged injured worker. If the pharmacist wants to accept assignment, he/she must resubmit the bill to the PBM with the Prior Authorization code of “999000000”. The co-payment field will default to “\$0.00”, and the alleged injured worker is supplied the medication at no charge. The bill information is then captured and suspended by the PBM.

The PBM will review all bills in a captured/suspended bill status on their system daily, and if a claim is found that matches the submitted eligibility information that is in an ALLOWED status, the bill is adjudicated and paid to the PHARMACY based on the PA code of “999000000”. If the claim is DISALLOWED, the bill will be denied and removed from the suspended bill file. If the bill is paid, the pharmacy will receive an additional fee of \$2.50 as payment for the risk associated with accepting assignment of the prescription.

2) Charge the injured worker:

The pharmacist should inform the alleged injured worker of the amount that he/she would have to pay in order to receive the medication which is the amount that was returned to the pharmacist when the initial submittal was denied. If the alleged injured worker agrees to pay for the medication, the pharmacist must then resubmit the bill information to the PBM with a Prior Authorization Code of “888000000”. The PBM will capture the bill information and return the amount to be paid by the alleged injured worker in the co-payment field on the prescription receipt.

The PBM will review all bills in a captured and suspended bill status within their system daily, and if a claim is found that matches the submitted eligibility information that is in an ALLOWED status, the bill is adjudicated and paid to the INJURED WORKER based on the PA code of “888000000”. If the claim is DISALLOWED, the bill will be denied and removed from the suspended bill file.

Denied Claims

For claims in a denied status, claims of a self-insured employer or claims of an employer that participates in BWC’s \$15,000 Medical Only deductible programs, the PBM notifies the pharmacist prior to the dispensing of the prescribed medication that the payment for the drug will not be made by BWC and is either the patient’s responsibility or the employer’s.

9. Reimbursement Rates

Single Source/Brand Drug: The lesser of Blue Book Average Wholesale Price (AWP) - 9% + \$3.50 dispensing fee or the provider’s Usual and Customary charge. The dispensing fee for prescriptions billed in “new claims” is \$6.00.

Multi-Source/Generic Drug: The lesser of Centers for Medicare & Medicaid Services (CMS) Federal Upper Limit (CMS FUL), Maximum Allowable Cost (MAC), Blue Book Average Wholesale Price (AWP) - 9%, + \$3.50 dispensing fee, or the provider’s Usual and Customary charge.

Accepting Assignment: If the pharmacist “accepts assignment” as described above, the dispensing fee will be \$6.00.

IMPORTANT: BWC does not distinguish between legend and over-the counter (OTC) medications when determining reimbursement. OTC drugs must be prescribed by a physician licensed to prescribe medications in order for the drug to be considered for reimbursement.

The state fund and self-insuring employers' pharmacy rules both state that the product cost component of payment for prescription drugs shall be AWP plus or minus a percentage. As such, the SI reimbursement rate is consistent with the state fund rate, that is, AWP -9%, plus a dispensing fee of \$3.50.

Self-insuring employers or their contracted PBM vendor may negotiate a lower or higher rate with pharmacy providers, however, pharmacy providers that do not enter into such agreements are entitled to payment at BWC's fee schedule amount and in no cases can the injured worker be balance billed by the provider. The SI employer cannot unilaterally impose a lower fee schedule than the amount allowed under BWC's fee schedule so when an injured worker uses a pharmacy that has not agreed to accept a lower amount, the PBM cannot refuse to accept the bills from the pharmacy or pay them at their network rate.

Relatedness editing and increasing the dispensing fee for initial prescriptions in new claims does not apply to Self-Insuring Employers.

10. Supply and Quantity Limits

BWC established maximum days supply and maximum quantity limits for both standard and catastrophic/chronic claim types. A standard claim can only receive the greater of a 34-day supply or 120 units per dispensing. Catastrophic claims may receive up to a 90-day supply with no quantity limitations.

11. Forms

Request for Prior Authorization of Medication (MEDCO-31): This form is used by the prescribing physician to request prior authorization for medications not typically used for industrial injuries or occupational disease. Fax completed MEDCO-31 forms to the PBM's Prior Authorization fax number, which is located at the bottom of the form for processing.

Formulary Medication Request Form (MEDCO-35): This form is used to request addition or deletion of a drug from the BWC formulary.

Outpatient Medication Invoice (C-17): Injured workers must use the C-17 form to get reimbursed for prescribed outpatient medication only. Injured workers can obtain all the information needed to complete the C-17 form at their pharmacy. Completed C-17 forms are submitted to the PBM with the medication labels with pricing information or a pharmacy printout with pricing information and the pharmacist's signature. For billing instructions on the (C-17), refer to Billing Instructions, Chapter 4. The invoice must then be mailed to:

**Catamaran
PO Box 968066
Schaumburg, IL 60196-8066**

Note: Injured workers whose employers are self-insuring should contact their employers for instructions on billing for outpatient medications. SXC Health Solutions is not responsible for processing bills in self-insuring claims.

Service Invoice (C-19) or CMS 1500: MCOs determine reimbursement eligibility for the following services that may be obtained in a pharmacy: durable medical equipment and disposable medical supplies. Contact the MCO for specific requirements for the use of the C-19 and CMS 1500. Note: BWC began accepting the new CMS-1500 (08/05) Jan. 2, 2007. However, because BWC is not a covered entity under HIPAA, BWC will accept either the 08/05 or the 2/20/12 version of the CMS-1500.

G. VOCATIONAL REHABILITATION SERVICES

Vocational rehabilitation provides individualized, comprehensive programs focused on safely returning eligible injured workers to work in a cost-effective manner. When injured workers quickly return to work or are able to maintain existing employment, case resolution progresses, lost time decreases, medical expenses decline and employers' costs may lessen.

Vocational rehabilitation case managers coordinate services and develop vocational rehabilitation plans. Plans must be written in accordance with the return to work hierarchy outlined in OAC 4123-18-05 to ensure the most permanent and cost effective re-employment of the injured worker. The hierarchy states that the goals of vocational rehabilitation are to return the injured worker to the:

- Same job, same employer;
- Different job, same employer;
- Same job, different employer; or
- Different job, different employer

Skill enhancement, remedial or short-term training may be used at any level of the hierarchy to aid injured workers in successfully returning to work.

1. Eligible Providers

A BWC enrolled provider must deliver any rehabilitation service including case management services provided to an injured worker. For BWC provider enrollment guidelines, refer to the General Information Chapter 1.

As outlined in OAC 4123-06-02.2(C) (44), in addition to their BWC enrollment, vocational rehabilitation case managers are required to hold a current certification as one of the following:

- Certified Rehabilitation Counselor (CRC);
- Certified Disability Management Specialist (CDMS);
- Certified Rehabilitation Registered Nurse(CRRN);
- Certified Vocational Evaluator (CVE);
- Certified Occupational Health Nurse (COHN);
- Certified Case Manager (CCM); or
- American Board of Vocational Experts (ABVE).

Note Vocational rehabilitation case management intern services must be provided by a BWC certified case management intern as outlined in OAC 4123-6-02.2(C)(45) (Please note that a vocational rehabilitation case management intern certification is only valid four (4) years and is not renewable.)*

Interns shall bill for their services using the W and Z codes associated with vocational rehabilitation case management. Interns will receive 85% of the fee schedule amount for all services excluding mileage at as outlined in OAC 4123-18-09 Appendix A.

2. Prior Authorization Information

The provider is responsible for contacting the appropriate MCO or self-insuring employer for authorization guidelines.

3. Covered Services

When the injured worker participates in MCO approved vocational rehabilitation plan activities, BWC reimburses or these services from its surplus fund. To receive reimbursement, a provider must:

- Submit a detailed report of the services rendered to the MCO; and
- Submit the results of those services to the MCO.

Vocational rehabilitation case managers, vocational rehabilitation case management interns and certain vocational providers may be eligible for reimbursement of pre-approved travel in accordance with the Vocational Rehabilitation Provider Fee Schedule OAC 4123-18-09 Appendix A.

The following definitions and procedures related to the Vocational Rehabilitation Provider Fee Schedule apply:

Plans with services paid “By Report” (OAC 4123-18-09)

- “By Report” codes are service codes that have no established fees for the identified service. The services include the following:
 - W0647 Automobile Repairs
 - W0648 Physical Reconditioning – Unsupervised
 - W0663 Job Modifications
 - W0665 Tools/Equipment
 - W0674 Child/Dependent Care
 - W0690 Training – Books, Supplies and Testing
 - W0691 Remedial Training
 - W0692 Short Term Training – up to 1 year
 - W0694 Long Term Training – over 1 year, includes supplies
- When including a “by report” code in a vocational rehabilitation plan, the Vocational Rehabilitation Case Manager (VRCM) will research the service that is needed. They will document in the vocational rehabilitation plan narrative the necessity for the service, the justification for the selection of provider and the reasonableness of the associated costs. The service and cost of the service will be included on the plan grid.
- When the MCO authorizes a vocational plan or amendment with a “by report” code, the MCO is responsible to enter a note summarizing their justification for the vocational necessity for the inclusion of the service paid by report, the reasonableness of the cost, and any negotiation attempts or cost analysis. The note will indicate the correct service code, the date range for the services from the plan grid, and the estimated fee approved on the plan.

Service Code Limits

Services listed as “maximum” shall be capped at the fee of units of service listed. When service caps or units of services are listed as “up to”, the cap may be exceeded with prior authorization upon presentation of the appropriate justification following “special plan type” guidelines.

Rounding

For all services with a fifteen (15) minute unit of service, providers shall round time spent providing the service to the nearest whole unit when billing.

Reimbursable Services

The following vocational rehabilitation services may be reimbursable when provided in an approved vocational rehabilitation plan or plan development activity:

1) Automobile repairs (W0647)

- This service provides payment for necessary repairs to an injured worker’s vehicle incurred during participation in a rehabilitation program and made for the sole purpose of allowing participation in rehabilitation program. The total cost of the repairs cannot exceed the trade-in value of the vehicle as reported in nationally recognized data (e.g., “Kelley Bluebook value” at www.kbb.com).
- Estimates on repairs must include a statement from the mechanic regarding the overall condition of the car.
- This by report service is provided on an individual basis as determined by need and must be provided by BWC enrolled providers. .
- Authorization of this service is subject to “special plan type” guidelines which require approval of the BWC Disability Management Coordinator (DMC).

- 2) **Biofeedback training** (Use **CPT® codes** for psycho-physiological therapy incorporating biofeedback training)
- Biofeedback training develops the injured worker’s ability to control the autonomic (involuntary) nervous system and aids in pain management.
 - Need for this service is determined on an individual basis.
- 3) **Body Mechanics Education (W0638)**
- Beginning August 1, 2011, this local code will no longer be available for use. Bill services using existing CPT codes for physical therapy as applicable.
- 4) **Child/dependent care (W0674)**
 This service provides reimbursement to an enrolled provider for care of a child or dependent of an injured worker with the sole purpose of allowing the injured worker to participate in their vocational rehabilitation program.
- This by report service is provided on an individual basis as determined by need and must be provided by BWC enrolled providers. The maximum hourly and weekly reimbursement rates shall be equal to the ODJFS rates set forth in the appendix to OAC 5101:2-16-41.
 - Authorization of this service is subject to “special plan type” guidelines, which require approval of the BWC Disability Management Coordinator (DMC).
- 5) **Counseling**
 Counseling assists injured workers in managing personal/emotional issues that interfere with vocational rehabilitation progress and present barriers to return to work. Eligible professional counseling services in the course of rehabilitation plans include:

Adjustment Counseling- a counseling service that assists an injured worker in managing the personal and emotional issues that interfere with vocational rehabilitation progress and return to work (Use **CPT® codes** for psychotherapy procedures).

Note If there is no psychological allowance in the claim, adjustment counseling is reimbursed as a Non-allowed Condition (see Non- allowed Conditions service later in this section.)*

Career Counseling – In Person, face to face and one-on-one (W0523)

This service specifically assists injured workers who require a substantial change in vocation due to the work related injury to identify and adjust to a new job goal that is realistic for their current physical and mental status, and for the availability of jobs in their chosen area of residence. These counselors may utilize a variety of assessments and techniques to help the injured worker explore areas of vocational interest. Once they have narrowed the occupational field, the counselor helps the injured worker identify the skills, training availability and earnings potential for the identified job. Progress notes, activity logs and a final report are required with this service. This service may be used in conjunction with W0524 Career Counseling – Research and Reporting. This service may be provided by a counselor who is licensed as one of the following:

- Licensed Social Worker (LSW);
- Licensed Independent Social Worker (LISW);
- Licensed Professional Counselor (LPC);
- Licensed Professional Clinical Counselor (LPCC);
- Licensed Psychologist;
- Doctor of Medicine (MD); or
- Doctor of Osteopathy (DO).

- *Providers of this service may be reimbursed for travel and mileage according to the codes for Other Provider Travel and Mileage. For this service, providers must bill under their individual provider number, not the company for which they work. Licensed Social Workers and Licensed Professional Counselors are reimbursed at 75% of the established fee, while Licensed Independent Social Workers and Licensed Professional Clinical Counselors will receive 85% of the established fee.*

Career Counseling – Research and Reporting (W0524) This service provides a limited amount of time for a career counselor to complete research of specific occupational requirements and/or report writing when the injured worker receiving career counseling is not present. The service may only be provided in conjunction with career counseling – in person as part of an approved vocational rehabilitation plan, and must be performed by the same person who is providing the career counseling services in the plan.

Guidelines for Career Counseling services

- At the start of career counseling, a written plan for the counseling should be developed with the injured worker. The plan should include:
 - Clearly defined goals for the service;
 - A list of individualized expectations for the injured worker while participating in career counseling;
 - A schedule of meeting dates (If this is a stand-alone service, these must be at least one (1) to three (3) times per week and include homework assignments.); and
 - An explanation of the homework that will be assigned and recognition that all services together for an injured worker shall approximate full-time or the level of the injured worker's release.
- The career counselor shall submit reports summarizing the progress of career counseling at least bi-weekly.
- At the end of the service, the career counselor shall submit a report providing the recommendations for vocational goal and relevant labor market information.
- When billing for career counseling, the counselor shall submit an activity log indicating dates of service, units of service billed, place and time of service delivery and, if applicable, a MEDCO-16.

6) Ergonomic Implementation (W0513)

Ergonomic Implementation allows for additional follow-up with the injured worker when a job modification is recommended. The purpose is to ensure that the modification is appropriate and that the injured worker is trained to use the modification correctly. This service may be provided by a(n);

- Occupational Therapist (OT);
- Physical Therapist (PT);
- Certified Professional Ergonomist (CPE);
- Certified Human Factors Professional (CHFP);
- Associate Ergonomics Professional (AEP);
- Associate Human Factors Professional (AHFP);
- Certified Ergonomics Associate (CEA);
- Certified Safety Professional (CSP) with “Ergonomics Specialist” designation;
- Certified Industrial Ergonomist (CIE);
- Assistive Technology Practitioner (ATP); or
- Rehabilitation Engineering Technologist (RET).

Providers of this service may be reimbursed for travel and mileage using fees and guidelines specified in W3050 Other Provider Travel, W3052 Other Provider Mileage, Z3050 RAW Service – Other Provider Travel or Z3052 RAW Service – Other Provider Mileage of the vocational rehabilitation provider fee schedule.

The provider must submit a detailed report summarizing the services provided with reimbursement requests. Services are reimbursed in fifteen (15) minute units up to sixteen (16) units.

7) Ergonomic Study (W0644)

An ergonomic study is an analysis of how the worker responds when performing the job in relation to the work environment. It examines the "fit" between the worker and the job requirements. An ergonomic study takes into account the worker's size, strength, ability to handle the tasks/ tools and work environment. It is generally used to evaluate the risks of the job and to recommend job modifications. This service is provided on an individual basis as determined by need. The provider of an ergonomic study must sign and date the study specifying his/her credentials. An ergonomic study may be provided by a(n):

- Occupational Therapist (OT) ;
- Physical Therapist (PT);
- Certified Professional Ergonomist (CPE);
- Certified Human Factors Professional (CHFP);
- Associate Ergonomics Professional (AEP);
- Associate Human Factors Professional (AHFP);
- Certified Ergonomics Associate (CEA);
- Certified Safety Professional (CSP) with "Ergonomics Specialist" designation;
- Certified Industrial Ergonomist (CIE);
- Assistive Technology Practitioner (ATP); or
- Rehabilitation Engineering Technologist (RET).

Providers of this service may be reimbursed for travel and mileage using fees and guidelines specified in W3050 Other Provider Travel , W3052 Other Provider Mileage , Z3050 RAW Service – Other Provider Travel or Z3052 RAW Service – Other Provider Mileage of the vocational rehabilitation provider fee schedule.

Services are reimbursed in fifteen (15) minute units up to twenty-eight (28) units.

8) Injured worker's meals (W0601) and lodging expenses (W0602)

BWC reimburses eligible injured worker's meals and lodging expenses on an individual basis as determined by need. IC/BWC guidelines and rates apply.

9) Injured worker's travel expenses (W0600)

BWC reimburses injured worker's travel expenses on an individual basis as determined by need with a minimum forty-five (45) mile round trip. IC/BWC guidelines and rates apply.

10) Injured worker travel, meals and lodging, (Program reimbursed, not reimbursed to the injured worker)

This service is provided on an individual basis as determined by need. The following local, level III HCPCS procedure codes are used when the vocational rehabilitation program (billing facility) used in the vocational rehabilitation plan has a contractual agreement with other facilities to provide travel, meals, and or lodging to the injured worker:

- Z0600 Vocational rehabilitation or chronic pain program, not claimant reimbursement, travel
- Z0601 Vocational rehabilitation or chronic pain program, not claimant reimbursement, meals
- Z0602 Vocational rehabilitation or chronic pain program, not claimant reimbursement, lodging.

11) Job Analysis (W0645)

A job analysis is a process for examining a job and collecting measurements while the job is being performed. It explains what the worker does, how the worker performs the work and what the outcomes of the work are. It identifies the essential functions of the job, describes the physical demands of the required tasks, working conditions and the knowledge, skill and experience generally required to safely perform the job. A job analysis includes information about the tools and equipment used in performing the job. A job analysis may be provided by a(n);

- Occupational Therapist (OT);
- Physical Therapist (PT);
- Certified Professional Ergonomist (CPE);
- Certified Human Factors Professional (CHFP);
- Associate Ergonomics Professional (AEP);
- Associate Human Factors Professional (AHFP);
- Certified Ergonomics Associate (CEA);
- Certified Safety Professional (CSP) with "Ergonomics Specialist" designation;
- Certified Industrial Ergonomist (CIE);
- Assistive Technology Practitioner (ATP); or
- Rehabilitation Engineering Technologist (RET).

Providers of this service may be reimbursed for travel and mileage using fees and guidelines specified in W3050 Other Provider Travel, Z3050 RAW Service – Other Provider Travel, W3052 Other Provider Mileage or Z3052 RAW Service - Other Provider Mileage of the vocational rehabilitation provider fee schedule.

The provider of a job analysis must sign and date the analysis specifying his/ her credentials. Services are reimbursed in fifteen (15) minute units up to sixteen (16) units.

*Note: * When the job analysis is provided by the vocational rehabilitation case manager, it is not billed using the W0645 code. It is considered vocational rehabilitation professional time.*

12) Job Club (W0641)

Job clubs are highly structured group meetings composed of job seekers and a facilitator. Participants cultivate skills through actively conducting their job search with training and guidance from the job club facilitator. This program aids a group of injured workers in obtaining job leads and supports their job search performance. Sessions must be facilitator led and at least one (1) hour in duration. *Reimbursement of this service is in six (6) minute units, up to two hundred (200) units in twenty (20) weeks.*

Mileage, travel time and wait time may also be billed by Job Club providers within BWC guidelines, see Other Provider Travel.

13) Job Coach (W0672)

A job coach is a vocational specialist who provides on-site guidance, training, and assistance to the injured worker focusing on job performance in the actual work situation. This behaviorally based program concentrates on teaching specific skills to assist in completing the job's required tasks and maintaining appropriate work behaviors. This service is customarily used with those individuals with traumatic brain injuries, psycho-behavioral conditions, catastrophic injuries and developmental disabilities. Employment must be secured in order to utilize this service. *Provision of this service is in fifteen (15) minute units for a maximum of one hundred and sixty (160) units.*

Mileage, travel time and wait time may also be billed by Job Coaching providers within BWC guidelines, see Other Provider Travel.

14) Job Modification (W0663)

A job modification is the removal or alteration of physical barriers that may prohibit an injured worker from performing the essential job functions and prevent the worker from returning to work or maintaining current employment. It may change the physical demands of the job, thus allowing the worker to perform their essential job functions without restrictions. Job modifications are generally used for a permanent position and not with a work trial unless the modification is portable.

Job modifications require prior approval by BWC and are provided on an individual basis as determined by need. Job modifications must be staffed and authorized by the BWC disability management coordinator (DMC) prior to final negotiations with the employer. Coordination among the employer, injured worker, physician of record and other professionals is required to ensure the suitability of the modification. The employer's signature is required on the vocational rehabilitation plan at the time of submission. An on-site job analysis or ergonomic study which includes the recommendations and justification for the modification and anticipated costs for the modifications is necessary to begin the process.

Use the W0663 code when reimbursing an approved service provider for a job modification. Do not use the W0663 code when reimbursing the employer for a job modification. When the employer provides the job modification, the DMC facilitates payments directly to the employer.

Fifty -percent (50%) of the costs are reimbursed to the employer upon completion of the job modification. The remaining fifty –percent (50%) is reimbursed after ninety (90) days provided the injured worker continues working with that employer.

15) Job Placement (W0660) and Job Development (W0659)

The specialized services of job placement and job development providers shall only be included in a vocational rehabilitation plan when the injured worker requires placement services above and beyond the services provided by the vocational rehabilitation case manager during the job search. The job placement and job development provider and the vocational rehabilitation case manager must staff the case to ensure the best coordination of the case. When using one of these services to negotiate a job offer with an employer, it is important that the job placement and job development provider work in conjunction with the BWC DMC and the vocational rehabilitation case manager. Specific compensation information should always be referred to BWC. The provider shall assist the injured worker in providing the MCO with documentation of all job contacts including employer name, date of contact, and the specific outcome.

The job placement and job development provider must complete a labor market analysis for the target job(s) prior to initiating job placement and job development services. The labor market analysis must include:

- Job availability within a certain industry; and
- The names of specific employers who are currently hiring.

Prior to the start of the job search, the job placement and job development provider shall develop a job search strategic plan with the vocational rehabilitation case manager. This job search strategy must include:

- A periodic re-evaluation of the direction of the job search; and
- Possible adjustments when expected outcomes are not reached.

Job placement and job development services are typically authorized in 4-6 week plans/amendments. Continuation of this service must be justified based on:

- The availability of openings for employment related to the identified job goal of the injured worker;
- The injured worker's possession of the expected skills for that job goal; and
- The injured worker's active participation in the job search process.

If the injured worker was identified as having transferable skills for the targeted job, but it is determined that the injured worker lacks a specific skill that is now expected by most employers for the job goal, training (on-the-job or short term) should be considered.

Comprehensive narrative reports for job placement and job development services must be provided. These shall include the injured worker's experience in job search and constructive advice provided by the job placement and development specialist.

*Note: *Job placement and job development providers must use their own servicing provider number when billing for services. Providers of this service may be reimbursed for travel, mileage and wait time according to the codes for Other provider Travel and Mileage..*

16) **Job Development (W0659)** is a vocational service that assists an injured worker in returning to work by uncovering the hidden job market (i.e., unadvertised positions) and/or creating a job that matches the injured worker's vocational skills and restrictions. Job development providers must:

- Have a working knowledge of an industry or geographic area and its employers to be effective;
- Have a marketing and sales frame of reference;
- Have awareness of both the injured workers' and potential employers' needs and knowledge of return to work incentive programs (e.g., Gradual Return to Work, Work Trial, Employer Incentive Contracts and On-the-Job Training);
- Use their knowledge and contacts from the local job market to facilitate return to work by contacting potential employers on behalf of the injured worker and arranging interviews for unadvertised or newly created jobs;
- Negotiate with potential employers to create a position for the injured worker that formerly did not exist; and
- When job development services are included in a vocational rehabilitation plan job placement services must also be provided. If the job placement provider is not the vocational rehabilitation case manager, the job development provider must either be the job placement provider or the vocational rehabilitation case manager.

Job Placement (W0660) is a vocational service that assists an injured worker in returning to work by matching the injured worker's vocational skills and restrictions with jobs that may be available or modified for the injured worker. Job placement providers use their knowledge and contacts from the local labor market to facilitate return to work by:

- Providing leads to the injured worker;
- Making contacts with potential employers on behalf of the injured worker for advertised jobs; and
- Matching an injured worker to an existing position in the community that may or may not require modifications to accommodate the injured worker's needs.

The job placement provider must also set job search procedures and goals, closely follow the injured worker's progress, and correct/redirect the performance of activities through frequent, documented face-to-face meetings with the injured worker. When job placement services are included in a vocational rehabilitation plan, job development services must also be provided. If the job development provider is not the vocational rehabilitation case manager, the job placement provider must either be the job development provider or the vocational rehabilitation case manager.

This service is reimbursed in six (6) minute units, up to 400 units (40 hours) in twenty (20) weeks.

17) Job seeking skills training (JSST) (W0650)

JSST is a specialized individualized or group program focused on job goals, application process and developing the skills necessary to obtain employment. This service is provided in person and is usually used in conjunction with job search, job club, or job placement and development. The focus includes:

- Proficiency in interviewing and how to address difficult interview questions, including questions about their disability and workers' compensation;
- Effective employer contacts with follow up;
- Internet job search;
- On-line job applications;
- Resume development;
- Managing electronic documents for job seeking;
- Using email related to job searches;
- Networking;
- Finding job leads; and
- Using form (RH10) for recording job contacts.

The provider must review the injured worker's presentation and provide tips on how to improve where necessary. The provider and the injured worker must develop a list of prospective employers and the provider must explain the different ways that successful contacts can be made. These would include:

- Face to face;
- Phone;
- Fax;
- US mail; or
- Internet contacts.

At the end of JSST, the provider must be able to provide concrete/objective support with documentation addressing:

- The information and content provided during the JSST program;
- The injured worker's strengths;
- Areas of additional need; and
- Whether the injured worker is ready for a job search.

JSST participants meet with the program instructor ten (10) to twenty (20) hours over one (1) to several weeks. The length of JSST is determined by the needs of the individual participant.

This service is reimbursed in six (6) minute units of service, up to 200 units (20) hours. Mileage, travel time and wait time may be reimbursed to a JSST providers within BWC guidelines, see Other Provider Travel.

18) Non-allowed Conditions (billing codes based on services provided)

Per OAC 4123-18-08 (B), non-allowed conditions may be treated within a vocational rehabilitation plan, up to \$2,000.00 maximum per claim, if these conditions are clearly aggravating the injury, preventing healing, impeding rehabilitation, or are barriers to return to work. Inclusion of a service for a non-allowed condition on a vocational rehabilitation plan, does not automatically invalidate BWC fee schedule limits and conditions. Services are subject to the appropriate BWC provider fee schedule to the maximum allowed per claim unless the required service is not part of the BWC fee schedule. (e.g., If eye glasses are included as a non-allowed condition, BWC would cover frames, and lenses that meet the injured worker's medical or vocational need in accordance with the fee schedule but generally not "deluxe" features such as designer frames, tint, etc.). If the service billed in this category is adjustment

counseling, it must be concurrent with vocational rehabilitation plan services and not the primary focus of the plan.

Medications for non-allowed conditions are not reimbursable. This may necessitate case closure until the achievement of medical stability.

19) Nutritional Consultation/Weight Control (W0750)

Services offered for weight reduction and weight maintenance when the condition presents a barrier to participation in vocational rehabilitation plan services and return to work. These services must focus on behaviorally oriented nutritional counseling and not on quick weight loss techniques primarily based on dieting supplements or packaged foods. If provided by a registered dietician, this service is paid in one-hour units, up to nine (9) units. Other programs operate within their customary timeframes during the rehabilitation plan.

20) Occupational Rehabilitation - Comprehensive, (Work Hardening) initial two (2) hour daily session (W0702), each additional hour (W0703)

A comprehensive occupational rehabilitation program is a multi-disciplinary, individualized, progressive therapy program with measurable outcomes. It focuses on assisting the injured worker return to work through progressive physical conditioning and work simulation.

In addition to therapy, occupational rehabilitation – comprehensive services assess the injured worker across a combination of disciplines and provides intervention to meet the needs of the injured worker to achieve a goal of returning to work. Part of this service is providing recommendations for reasonable accommodations or adaptations to the work environment while minimizing the risk of re-injury.

To be eligible for reimbursement the provider must have valid CARF accreditation for occupational rehabilitation – comprehensive services. Part of the initial C-9 authorization for occupational rehabilitation – comprehensive is the evaluation by an OT or PT at the start of the program; however, it is billed separately using CPT codes. The following are treatment indicators for an occupational rehabilitation – comprehensive program:

- The injured worker has no specific job to return to with a specific employer but has a targeted job (or job group). While the goal appears realistic, the injured worker does not currently have all of the physical tolerances for the targeted job; or
- The injured worker has a specific job to return to with a specific employer, but does not currently have the physical capacities to safely return to the job and/or the employer does not have appropriate job accommodations; or
-
- The injured worker presents with more severe vocational issues or has complications beyond physical impairments that require an interdisciplinary team approach to address physical, psychological and vocational issues.

W0702 initial two (2) hour session is reimbursed in fifteen (15) minute units of service for a maximum of eight (8) units per day and up to 320 units in eight (8) weeks. W0703 reimburses each additional hour in fifteen (15) minute units up to 960 units in eight (8) weeks.

21) Occupational Therapy/Physical Therapy (See CPT® codes)

For occupational therapy (OT) or physical therapy (PT) services to be included within a vocational rehabilitation plan, the services must simulate the work tasks of the injured worker's job or job goal. Active occupational or physical therapy services may be provided in the rehabilitation plan, as long as they are provided in conjunction with services that simulate the work tasks of the injured worker's job or job goal.

‘Active’ physical or occupational therapy services are:

- Provided after the acute recovery phase;

- Not passive modalities;
- Focused on overall body conditioning and not body part specific; and
- Focused on return-to-work goals.

OT or PT services require written justification within the plan narrative of how the service specifically addresses the return-to-work goal and must include justification for length of services. No passive modalities (e.g., massage, ultrasound, etc.) may be charged to the surplus fund, even if provided on a limited basis within an active OT/PT program. These services are allowable up to six (6) weeks. The minimum acceptable level of participation is three (3) days per week if the service is the only service in a plan.

*Note *Travel and mileage expenses are not reimbursable to service providers.*

22) Physical Reconditioning Unsupervised (W0648)

This service provides short-term membership to a health club, YMCA, spa or nautilus facility when requested by the physician of record to allow the injured worker to independently continue or maintain physical conditioning necessary for return to work. Use W0648 only in an approved vocational rehabilitation or remain at work program. It does not include supervision by a licensed physical therapist. The vocational rehabilitation plan must describe the injured worker's expected activities and the frequency of participation per week. An unsupervised program must not be the only service in the rehabilitation plan. Only one (1) program is reimbursable per referral for vocational rehabilitation services. This service is limited to one (1) three-month program per referral for vocational rehabilitation services, with a reimbursement maximum of \$225.00 for the entire program.

23) Relocation Expenses (Z0700)

Reimbursement for relocation expenses is paid by report, on an individual basis as determined by need, to a maximum of \$2,000. These services provide financial assistance to injured workers that have obtained employment and must relocate because the job location is beyond the reasonable expectation of daily commuting.

24) Retraining Exercise Equipment (W0695)

As of October 1, 2012, this code is no longer available for use.

25) Situational Work Assessment (W0635)

This assessment is a simulated tryout of the job or job family evaluating an injured worker's ability to perform specific job tasks. The rehabilitation plan must include details about the tasks the injured worker will be assigned and the name and contact information for the person acting as trainer/evaluator on the job-site. The trainer shall provide a report on the injured worker's attendance and performance on the Trainer Report (RH-5) or its equivalent.

*Note *This service is reimbursed in fifteen (15) minute units for a maximum of 160 units or 40 hours.*

26) Tools and Equipment (W0665)

This service, which is provided on an individual basis as determined by need, provides tools and/or equipment (e.g., chairs, etc.) necessary for employment of the injured worker once s/he has obtained a job, or has an approved rehabilitation plan that requires specific tools /equipment. The vocational rehabilitation case manager and injured worker sign the Loan/Release Agreement for Tools and Equipment (RH-7) at the time of successful return to work or delivery of the equipment if used in a rehabilitation plan. Prior to including the tools/equipment on a plan the provider must check with the DMC for availability of the items on the tools and equipment tracking list. The vocational rehabilitation case manager shall inform the injured worker that the tools/equipment are the property of BWC and may be reclaimed should vocational rehabilitation prove to be unsuccessful (i.e., the injured worker is not working ninety (90) days after return to work). If the injured worker has maintained employment for ninety (90) days, the MCO releases the tools /equipment to the injured worker by signing the appropriate section of the RH-7. If the injured worker is seeking employment and needs the equipment to obtain employment, the MCO shall discuss with the DMC, who may provide a loan extension. This service is reimbursed by report to BWC enrolled providers.

*Note: * Any items that have an associated CPT code shall be billed as a non-allowed condition using the appropriate code.*

27) **Training/Skill Enhancement**

Training – Books, Supplies & Testing (W0690)

This service provides reimbursement for books, supplies, and testing necessary for participation in or completion of a training program. Books and supplies are limited to the course-required books, manuals, software, and equipment. This service is not intended to reimburse incidental supplies, such as pens, pencils, notebooks, highlighters, etc., unless the course requirements specifically include those items. Reimbursement for testing may include fees for testing and required certifications or other occupationally required testing, such as background checks, credentialing, and licensing. This service is reimbursed by report.

Remedial Training (W0691)

Remedial training assists injured workers in developing academic skills toward completion of their GED or remediation classes needed for admission to a training program beyond the high school level, such as business or trade school. In some situations, “distance education”, also called e-learning or on-line learning, in which the student communicates with the instructor via the internet is permissible. Typically, GED training should not be the only service in a plan.

Except as otherwise provided below, remedial training must be in the form of organized instruction provided by an academic, business, and/or trade school, that meets at least one of the following criteria:

- Designated by the Ohio Board of Regents as a college or university;
- Identified as an Adult Basic Literacy Education (ABLE) provider;
- Identified as an Ohio Adult Workforce Education (AWE) provider;
- Granted a certificate of authorization from the Ohio Board of Career Colleges and Schools;
- Approved by the appropriate state licensing board, department, or commission for training in a specific field;
- Certified as an eligible training provider by state and local Workforce Investment Boards (WIB) and the Ohio Department of Job and Family Services;
- Chartered or certified by the Ohio Department of Education; or
- Accredited by an accrediting body recognized by the U.S. Department of Education.

In addition, remedial training may also be provided by:

- An instructor certified or licensed by the product’s developer, manufacturer or distributor;
- A teacher certified by the State of Ohio;
- A person employed as an instructor by an accredited college or school; or
- A provider accredited by CARF International.

*Note *Providers who were reimbursed for this service code by BWC for dates of service between September 1, 2009 and August 31, 2012 may continue to receive reimbursement for this service code for dates of service on or after September 1, 2012, even if they do not meet any of the criteria identified above. Reimbursement of this service is by report.*

Short Term Training up to one year (W0692) and Long Term Training over 1 year (W0694)

Both short and long-term training include training and skill enhancement that assists injured workers in developing new occupational skills. Short term training lasts up to one (1) year and long-term training is from one (1) to two (2) years in duration. Except as otherwise provided below, short and long term training must be in the form of organized instruction provided by an academic, business, or trade school that meets at least one of the following criteria:

- Designated by the Ohio Board of Regents as a college or university;
- Identified as an Ohio Adult Workforce Education (AWE) provider;
- Granted a certificate of authorization from the Ohio Board of Career Colleges and Schools, approved by the appropriate state licensing board, department, or commission for training in a specific field;
- Certified as an eligible training provider by state and local Workforce Investment Boards (WIB) and the Ohio Department of Job and Family Services;
- An apprenticeship provider identified as a Registered Apprenticeship by the U.S. Department of Labor or the Ohio State Apprenticeship Council;
- A person who has achieved mastery of a particular field by certification, licensing or experience;
- Chartered or certified by the Ohio Department of Education; or
- Accredited by an accrediting body recognized by the U.S. Department of Education.

Short-term training may also be provided by:

- An academic, business, or trade school identified as an Adult Basic Literacy Education (ABLE) provider
- An instructor certified or licensed by the product's developer, manufacturer or distributor;
- A teacher certified by the State of Ohio;
- A person employed as an instructor by an accredited college or school; or
- A provider accredited by CARF International.

*Note * Providers who were reimbursed for these service codes by BWC for dates of service between September 1, 2009 and August 31, 2012 may continue to receive reimbursement for this service code for dates of service on or after September 1, 2012, even if they do not meet any of the criteria identified above.*

Both short and long -term training justification must:

- Include a transferable skills analysis (TSA) and labor market survey (LMS) (see definitions below).
 - The labor market survey must indicate that the targeted occupation(s) will be available in sufficient quantity upon completion of training program.
- Address medical/physical documentation indicating that the injured worker can perform the physical aspects of the training and the job tasks.

Long-term training services

Long-term training requires prior approval from BWC. In some situations, “distance education” also called e-learning or online learning in which the student communicates with the instructor via the internet is allowable. Long-term training must:

- Be provided at schools with effective employment placement programs. (Documentation of the placement statistics, when available, from the school, is required.)
- Include a comprehensive vocational evaluation. The vocational evaluation must address the injured worker’s academic abilities and other relevant vocational factors in relation to the requirements of the training program and the targeted job. The vocational evaluation must also provide a professional opinion regarding the injured worker’s chances for success at training and resulting employment.

Long-term training service is directed toward obtaining one of the following relating to an injured worker’s vocational goal:

- A degree;
- A diploma;
- A certification;
- Licensure; or
- A certificate.

Requirements for continuation of a long-term training plan

The vocational rehabilitation case manager must submit a copy of the injured worker’s official grade report to the DMC at the end of each grade period verifying full-time attendance and successful completion of course work. Successful completion of course work means documentation of receipt of a 2.0 grade point average while carrying a full-time course load (generally 12-15 credit hours). If grades fall below a 2.0 or attendance is less than full-time, the MCO may permit a one-term extension to allow the injured worker to improve grades or increase course load.

Note #1: Less than full-time attendance may occur due to class scheduling situations that are no fault of the injured worker. If this occurs, the case manager must provide documentation to the MCO verifying this situation. In these situations, the case manager must also coordinate the injured worker’s involvement in other relevant vocational activities to assure full-time participation and continuation of living maintenance. Relevant vocational activities may include but are not limited to:

- Conducting informational interviews;
- Researching occupational opportunities via classified advertisements or the internet; and
- Preparing a resume or engaging in other appropriate job seeking skills.

Note #2: If no courses are available for a one-term period, through no fault of the injured worker, and the injured worker is not participating in any other vocational activities, the rehabilitation plan may be interrupted for the term without payment of living maintenance (LM) compensation. The case manager should notify the DMC when this occurs. The customer care team (CCT) should facilitate the reinstatement of any other form of compensation when LM stops, if the injured worker is otherwise eligible.

Definitions:

- **Transferable Skills** -work tasks learned and performed on the job generally in the last fifteen (15) years that the injured worker can physically perform and would reasonably equip the job seeker to compete with other candidates. Transferable skills are generally not aptitudes or capabilities to learn a new skill, but a skill the injured worker has performed for a sufficient duration, leading to competence in performing the skill.
- **Transferable Skills Analysis (TSA)**- an analysis of the injured worker’s residual skills in order to identify job tasks and occupations that can be safely performed. The TSA must specify the assessment method used (e.g., VDARE, OASYS) and the results. The TSA is a tool, used along with other sources of information, to help determine an appropriate vocational direction.
- **Labor Market Survey for training plans**- an analysis of the appropriateness of the targeted occupation based on labor market factors. The assessment documents the growth potential of the occupation in the local labor market along with salary estimates for new graduates. The assessment method used for the analysis (e.g., internet sources of labor market data, software programs, etc.) must be identified.

28) **Transitional Work Services (W0637)**

Transitional Work services are provided to an injured worker at the work site by an Occupational Therapist (OT) or a Physical Therapist (PT). The services primarily focus on using the injured worker’s functional work tasks to progress the worker to a target job. Progressive conditioning, therapeutic exercises, training in safe work practices such as proper body mechanics and other work-site services may also be used as part of the therapeutic program developed for that injured worker. Transitional Work services are separate and distinct from on-site occupational or physical therapy services provided to injured workers at the work site.

Transitional work services are usually provided within an overall transitional work program. A transitional work program is a work-site program that provides an individualized interim step in the recovery of an injured worker with job restrictions resulting from the allowed conditions in the claim. The overall program is developed in conjunction with the employer, the collective bargaining agent (where applicable) and rehabilitation professionals. The services must be provided within a specified time limit which is usually determined by the overall transitional work program guidelines if there is a transitional work program in place. If there is not a transitional work program in place, the time limit is defined by the vocational rehabilitation plan and generally does not exceed twelve (12) weeks.

When reporting Transitional Work services, the actual servicing provider must:

- Identify services provided;
- Report injured worker’s present status;
- Identify the goal and timeframes to achieve the goal;
- Identify the plan to achieve the goal with timeframes;
- Sign and date reports, specify credentials and license number; and
- Report the time spent delivering services to injured worker

Transitional Work services may be continued after the injured worker has been released to full-time, regular duty with MCO authorization to insure that the injured worker has achieved a stable return to work. Transitional Work services should generally be provided in one (1) to two (2) hour time frames since some jobs repeat similar duties multiple times. Transitional work services over two (2) hours shall be closely monitored by the MCO. Initial evaluations must not exceed three (3) hours.

An injured worker may receive transitional work on-site therapy services as part of the presumptive authorization program, as described in chapter 1 of this manual. In this case, a C-9 must be submitted prior to the implementation of services. The presumptive authorization program permits up to ten (10) “sessions” of transitional work on-site therapy services.

*Note * Providers may be reimbursed for travel or mileage using fees and guidelines specified in W3050 Other Provider Travel or Z3050 RAW Service – Other Provider Travel, and W3052 Other*

Provider Mileage or Z3052 RAW Service - Other Provider Mileage of the vocational rehabilitation provider fee schedule. Reimbursement for Transitional Work services is in fifteen (15) minute units for a maximum of 192 units (48 hours).

29) Vocational Evaluation: Vocational Screening (W0631), Comprehensive Vocational Evaluation (W0610)

A vocational evaluation is a process, which gathers vocational information about an injured worker, typically using real or simulated work, to assist in determining vocational direction. This service requires detailed written documentation including time spent for assessment and report writing. Transferable skills analysis is a necessary component of reimbursable vocational evaluations. The overall results are based on integrating the injured worker's physical capacities, medical, psychological, and vocational data with realistic vocational options that exist in the labor market.

Types of vocational evaluation:

Vocational Screening (W0631)

The vocational evaluator uses simple paper and pencil tests and transferable skills analysis to make recommendations about the vocational goal of the injured worker. The evaluator relies primarily on vocational interview, physician's reports of the injured worker's capacities, and the injured worker's self-reports of interests and job history. Vocational screenings may be conducted by a:

- CRC;
- CDMS;
- COHN;
- CCM;
- CVE;
- CRRN; or
- ABVE.

Reimbursement for this service is in six (6) minute units for a maximum of forty (40) units (4 hours).

Comprehensive Vocational Evaluation (W0610)

This process requires a certified vocational evaluator to gather vocational information about an injured worker, usually through the use of real or simulated work to assist in determining vocational direction. The vocational evaluator uses extensive client interview and vocational exploration, as well as, psychometric testing which may include aptitude, dexterity, academic and vocational interest testing. The overall result is a report that provides recommendations about the injured worker's options for returning to work within a vocational rehabilitation program. The report is based on integrating the injured worker's residual transferable vocational skills with their current physical capacities and realistic return to work options that exist in the current labor market. Comprehensive vocational evaluations may be conducted by a:

- CRC;
- CVE;
- ABVE; or
- Licensed psychologist.

A comprehensive vocational evaluation must address the injured worker's academic abilities and other relevant vocational factors in relation to the requirements of any proposed training program or targeted job. The evaluator must provide a professional opinion regarding the injured worker's chances for success at any proposed training and resulting employment.

*Note * Reimbursement for this service is in six (6) minute units for a maximum of 120 units (12 hours). Mileage, travel time and wait time may also be billed by vocational evaluation providers (screening and comprehensive) within BWC guidelines, see Vocational Rehabilitation Other Provider Travel.*

30) **Vocational Exploration and Guidance** (to be included within Vocational Rehabilitation Case Management Professional Time)

Vocational exploration and guidance provides time for the vocational case manager to:

- Assist the injured worker in formulating a new vocational direction when it is determined that the injured worker cannot attain the physical requirements necessary for the previously identified vocational goal. The vocational rehabilitation plan must identify the specific methods used to clarify the vocational goal (e.g., face-to-face meetings with the injured worker to review vocational interests or work history, etc.).
- Wait for information from the physician of record or other evaluations to provide case direction after completion of a rehabilitation program (i.e. work hardening).

Only the assigned case manager may provide vocational exploration and guidance. It may not be offered as the first service in an initial vocational rehabilitation plan or following a medical interrupt. There is no reimbursement specifically for this service description. Reimbursement is made using the case management codes. This service should not exceed four (4) weeks.

31) **Vocational Rehabilitation Case Management**

Vocational rehabilitation case managers (VRCMs) develop and coordinate a variety of restorative services with the goal of assisting the injured worker to remain at work or to return to work.

For an injured worker who is eligible and feasible for vocational rehabilitation plan services under OAC 4123-18-03, the actual time spent in providing case management services is billed to the BWC surplus fund. Bills must report the specific date of the activity with each separate date of service reported on a separate line (line-by-line billing). Reports of activities must always identify the specific party contacted. Only BWC enrolled vocational rehabilitation case managers or vocational case manager interns may bill for vocational rehabilitation case management services. The individual who actually performs the service is identified as the servicing provider. Vocational rehabilitation case management services provided by interns will be reimbursed at 85% of the case manager rates. Mileage for interns will be at regular rates. Reimbursement for this service is in six (6) minute units of service.

When vocational rehabilitation case management services are provided to injured workers with medical only claims as a Remain at Work (RAW) service, the focus is on keeping the injured worker on the job. RAW case management services use Z-codes instead of W-codes and the services are charged to the employer's risk.

The following codes are used for vocational case management services.

Telephone calls/e-mails to/from the vocational rehabilitation case manager (specific codes listed in chart below)

The actual time spent sending and receiving phone calls and e-mails as part of vocational rehabilitation case management duties.

Billing exclusions:

- Voice mail messages beyond one (1) unit (6 minutes) per call. (note: reimbursable voice mail messages must briefly address issue and be documented);
- Unanswered phone calls without voice mail message;
- Courtesy copies (cc) of e-mails;
- Telephone or e-mail staffing within the vocational rehabilitation case management company, unless the staffing is with a co-worker assigned to the case;
- Telephone or e-mail staffing between the vocational rehabilitation case manager intern and the supervising case manager; and
- Telephone calls or e-mails regarding case management billing or reimbursement issues.

Phone call/email to/from:	Surplus-funded plan:	RAW service
Injured worker or representative	W3000	Z3000
Physician or representative	W3001	Z3001
Employer or representative	W3002	Z3002
BWC	W3003	Z3003
MCO	W3004	Z3004
Service provider	W3005	Z3005
Other- (must specify)	W3006	Z3006

Face-to-face meetings with vocational rehabilitation case manager

The actual time spent in a face-to-face meeting to staff the rehabilitation case, coordinate services or provide other necessary communication.

Billing exclusions:

- Face-to-face supervision or staffing within the vocational rehabilitation company. This does not include staffing between a vocational rehabilitation case manager and other servicing providers included on a rehabilitation plan within the same company (e.g.,, billing for staffing between the vocational rehabilitation case manager and the job placement provider is appropriate).

Face-to-face meeting with:	Code when provided in a surplus-funded plan:	Code when provided as a RAW service for a medical only claim:
Injured worker or representative	W3010	Z3010
Physician or representative	W3011	Z3011
Employer or representative	W3012	Z3012
BWC	W3013	Z3013
MCO	W3014	Z3014
Service provider	W3015	Z3015
Other- (must specify)	W3016	Z3016

Documentation review by vocational rehabilitation case manager

The actual time spent reviewing medical, psychological and vocational information from reports, files and e-mail correspondence. Reports must specify type and source information reviewed.

Code when provided in a surplus funded plan: **W3020**

Code when provided in a RAW case: **Z3020**

Initial assessment report writing by vocational rehabilitation case manager

The actual time spent writing the initial vocational rehabilitation assessment report. Report must include all relevant history and demographic information.

Code when provided in a surplus funded plan: **W3025**

Code provided in a RAW case: **Z3025**

Plan writing by vocational rehabilitation case manager

The actual time spent writing the initial or amended rehabilitation plan. Only time spent writing new/original information is reimbursable.

Billing Exclusions:

- Time spent “cutting and pasting” previously submitted information

Code when provided in a surplus funded plan: **W3030:**

*Note: * There is no corresponding Z- code for this service.*

Report writing by vocational rehabilitation case manager

The actual time spent in writing vocational rehabilitation progress report, labor market report, closure report and letters/correspondence. Only time spent writing new/original information is reimbursable.

Billing Exclusions:

- Time spent “cutting and pasting” previously submitted information
- Time spent preparing or submitting billing documentation

Code when provided in a surplus funded plan: **W3035**

Code when provided in a RAW case: **Z3035**

*Note: * Writing the initial assessment report, vocational rehabilitation plan and transferable skills analysis report is not billed using this code; see specific codes for writing these reports.*

Letters/Correspondence writing by vocational rehabilitation case manager

The actual time spent in developing/writing letters and correspondence including new/original information that is faxed or emailed.

Billing exclusions:

- Time spent submitting the information (actual faxing or emailing)

Code/Reimbursement when provided in a surplus funded plan: **W3036**

Code/Reimbursement when provided in a RAW case: **Z3036**

Labor Market Survey (LMS) by the vocational rehabilitation case manager

The actual time spent researching, developing and writing the LMS report when completed by the vocational rehabilitation case manager assigned to the rehabilitation plan. Use this code only when the vocational rehabilitation case manager is preparing an LMS independent of a vocational evaluation or career counseling report.

Billing exclusion:

- Time spent submitting the information (actual faxing or emailing)

Code/Reimbursement: **W3039**

Transferable Skills Analysis (TSA) report writing by vocational rehabilitation case manager

The actual time spent developing and writing the TSA report. This report systematically analyzes an injured worker’s residual skills in order to determine jobs or job tasks that can safely be performed. The TSA report must be submitted and it must specify assessment method used (i.e. VDARE, OASYS) and the results.

Code when provided in a surplus funded plan: **W3040**

Code when provided in a RAW case: **Z3040**

*Note: * For Vocational Rehabilitation Case Manager Mileage, Travel time and Wait time for services see Vocational Rehabilitation Provider Travel.*

Guidelines for attending physician appointments: A case manager must receive permission in advance from the injured worker and the physician’s office when planning to attend a physician appointment with the injured worker.

Guidelines for managing out-of-state cases: When an MCO is providing vocational rehabilitation case management services for an injured worker whose residence is not in Ohio, a case manager in close proximity to the injured worker must provide these services. The out-of-state vocational rehabilitation case manager must become BWC enrolled to provide services under the direction of the Ohio MCO in accordance with the MCO Policy Reference Guide. To prevent service delays, the out-of-state case manager may begin providing vocational rehabilitation case management services after case assignment and application for provider enrollment, but before the confirmation of enrollment. To

expedite the enrollment process, the MCO may complete and sign a MCO non-certified application and fax that to their representative on the provider enrollment team then follow-up with the MEDCO 13, completed and signed by the provider.

Only the assigned out-of-state vocational rehabilitation case manager may incur vocational rehabilitation case management charges.

32) **Vocational Rehabilitation Provider Travel** (includes Mileage, Travel time and Wait time)

Vocational Rehabilitation Case Manager Travel Time

Vocational rehabilitation case manager travel time is the actual time spent traveling to or from necessary vocational rehabilitation appointments by the vocational rehabilitation case manager (VRCM) to meet with the injured worker, employer, physician of record, or other vocational rehabilitation provider. In most cases, the vocational rehabilitation case manager may be reimbursed up to one hour of travel time each way for a necessary trip. If multiple appointments related to an injured worker's rehabilitation case occur on the same day within the same area, additional appropriate travel time and mileage may be charged. This is reimbursed in six (6) minute units of service up to 10 units each way of a necessary trip.

Code when provided in a surplus funded plan: **W3045**

Code when provided in a RAW case: **Z3045**

Vocational Rehabilitation Case Manager Wait Time

Vocational rehabilitation case manager wait time is the actual time spent waiting by the vocational rehabilitation case manager for the injured worker, employer, physician of record, or other vocational rehabilitation provider. Wait time begins at the scheduled appointment time and may be billed a maximum of five (5) units per occurrence (30 minutes) including "no shows". This service is reimbursed in six (6) minute units of service.

Code when provided in a surplus funded plan: **W3046**

Code when provided in a RAW case: **Z3046**

Vocational Rehabilitation Case Manager Mileage

This code provides reimbursement for actual miles traveled by the vocational rehabilitation case manager to meet with the injured worker, the employer, the physician of record, or other vocational rehabilitation providers. Mileage is reimbursed up to 65 miles one way. Mileage must be in accordance with vocational rehabilitation case manager travel guidelines outlined below. The reimbursement is per mile.

Code when provided in a surplus funded plan: **W3047**

Code when provided in a RAW case: **Z3047**

Other Provider Travel Time

Other provider travel time is the actual time spent traveling to or from necessary vocational rehabilitation appointments to meet with the injured worker or employer by a provider of the following services:

- Job club*;
- Job coaching; Job placement*;
- Job development*;
- Job seeking skills training*;
- Vocational screening;
- Vocational evaluation;
- Ergonomic study;
- Ergonomic implementation;
- Job analysis;
- Transitional work; and/or
- Career counseling – in person*.

Reimbursement for provider travel is in six (6) minute units of service up to ten (10) units of service one way. If multiple appointments related to multiple injured workers occur on the same day within the same area, travel time must be pro-rated to the various claims.

Billing exclusions:

- Travel for the purpose of mailing vocational rehabilitation material;

Code when provided in a surplus funded plan: **W3050**

Code/Fee Schedule when provided in a RAW case: **Z3050** Note: * Travel time in a RAW plan is not eligible for reimbursement for job club, job placement, job development, job-seeking skills training, and career counseling – in person.

Other Provider Wait Time

Other provider wait time is the actual time spent waiting for the injured worker by a provider of the following services:

- Job club*;
- Job coaching;
- Job placement*;
- Job development*;
- Job seeking skills training*;
- Vocational screening
- Vocational evaluation.

Wait time begins at the scheduled appointment time and may be billed for a maximum of five (5) units of service per occurrence (30 minutes) including “no shows”. Reimbursement is in six (6) minute units. Note: * Wait time in a RAW plan is not eligible for reimbursement for job club, job placement, job development, and job-seeking skills

Code when provided in a surplus funded plan: **W3051**

Code/Fee Schedule when provided in a RAW case: **Z3051** Note: * Wait time in a RAW plan is not eligible for reimbursement for job club, job placement, job development, and job-seeking skills training, ~~and career counseling – in person.~~

Other Provider Mileage

Reimbursement for actual miles traveled to attend necessary meetings with the injured worker or employer by a provider of the following services:

- Job club*;
- Job coaching;
- Job placement*;
- Job development*;
- Job seeking skills training*;
- Vocational screening;
- Vocational evaluation;
- Ergonomic study;
- Ergonomic implementation;
- Job analysis;
- Transitional work; and/or
- Career counseling – in person*.

Mileage is reimbursed per mile up to 65 miles one way

Code when provided in a surplus funded plan: **W3052**

Code/Fee Schedule when provided in a RAW case: **Z3052** Note: * Mileage in a RAW plan is not eligible for reimbursement for job club, job placement, job development, job-seeking skills training, and career counseling – in person.

Rehabilitation Provider Travel Guidelines:

- If there are no vocational rehabilitation case managers available within one (1) hour or sixty five (65) miles of the IW, the next closest provider will be reimbursed in full for mileage and travel time.
- If by the IW's or MCO's choice a provider greater than sixty-five (65) miles away is chosen when there are eligible providers within sixty-five (65) miles of the IW, mileage and travel time are reimbursed at a maximum of sixty-five (65) miles and one (1) hour each way.
- If multiple appointments related to an injured worker's rehabilitation case occur on the same day within the same area, additional appropriate travel time and mileage may be charged.
- For job placement and job development occurring in an approved vocational rehabilitation plan, additional appropriate travel time and mileage may be considered if multiple appointments with the injured worker or employers related to an injured worker's rehabilitation plan occur on the same day within the same area.
- If it is expected that the one-way, single appointment travel or mileage guidelines will be exceeded for a necessary trip to meet with an injured worker, employer or provider, prior approval is needed in order for the provider to be reimbursed as per special plan types. This does not apply if the mileage exceeds one-way travel or mileage guidelines because of multiple appointments in a trip.
- If multiple appointments related to multiple injured workers occur on the same day within the same area, travel time and mileage must be pro-rated and fairly apportioned to the various claims.

33) Work Adjustment, Facility Based (W0662), Employer Based (W0620)

Work adjustment is a specialized structured program that uses an employer's work site or a facility site to improve an individual's work abilities, skills and behaviors. The injured worker experiences training or work situations within the facility or employer site, their overall performance is assessed and specific measurable goals are developed to improve their performance to facilitate successful return to work. Work adjustment services focus on both the specific job skills and the soft skills associated with employment, such as:

- Stamina;
- Grooming and hygiene;
- Attendance;
- Punctuality;
- Social skills;
- Team work;
- Problem solving;
- Customer service; and
- Productivity.

If the sole focus of the program is skill enhancement, it is not a work adjustment program. Weekly attendance reports and at least bi-weekly progress report must be submitted by the MCO while the injured worker is participating in these services. Service providers are not reimbursed for travel or mileage for these services. Minimum expected participation is typically three (3) days per week four (4) hours per day. Any services below this level should be staffed by the vocational rehabilitation case manager, the MCO and the DMC.

Work Adjustment - Facility Based (W0662)

Services occur within a facility and the injured worker experiences training or work situations as part of this service. Reimbursement is in fifteen (15) minute units of service, maximum of 140 units per week for twelve (12) weeks.

Work Adjustment - Employer Based (W0620)

Services occur within an employer's work site and the injured worker experiences real work situations as part of this service. Reimbursement is in fifteen (15) minute units of service, maximum of 140 units per week for four (4) weeks.

34) Work Conditioning (W0710)

A Work Conditioning program consists of a progression of treatments using physical conditioning and job simulation/real work tasks to help the injured worker regain optimal function and return to work. The program goals should address:

- Improvements in cardiopulmonary function;
- Improvements in neuromuscular function;
- Improvement in musculoskeletal function;
- Education;
- Symptom relief; and when appropriate,
- Reasonable accommodations for the worker and adaptations to the work environment.

The following are treatment indicators for a work conditioning program:

- 1) The injured worker has no specific job to return to with a specific employer but a targeted job (or job group) goal. While the goal appears realistic, the injured worker does not currently have all of the physical tolerances for the targeted job; or
- 2))The injured worker has a specific job to return to with a specific employer, but does not currently have the physical capacities to safely return to the job and/or the employer does not have appropriate job accommodations; and
- 3) The injured worker does not require interdisciplinary services since the impediments to return to work are primarily physical. (During the program the need for a limited number of individualized services such as OT, PT, psychological or nutritional services may occasionally arise.) *

*Note * Bill these services using CPT® codes.)*

Reimbursement of work conditioning is in fifteen (15) minute units, up to 640 units in eight (8) weeks, usually 2-4 hours per day.

Vocational Rehabilitation Codes in Numerical Order

W0513	Ergonomic Implementation, 15 minute unit, up to 16 units
W0523	Career Counseling – In Person, 6 minute unit up to 100 units or 10 hours
W0524	Career Counseling – Research and Reporting, 6 minute unit, maximum of 40 units or 4 hours
W0600	Injured worker travel expenses in specific situations; injured worker reimbursed
W0601	Injured worker meal expenses in specific situations; injured worker reimbursed
W0602	Injured worker lodging expenses in specific situations; injured worker reimbursed
W0610	Comprehensive Vocational Evaluation, 6 minute unit. Maximum 120 units or 12 hours.
W0620	Work Adjustment - Employer Based, per 15 minute unit. Maximum 140 units 35 hours per week for 4 weeks.
W0631	Vocational Screening, per 6 minute unit. Maximum 40 units or 4 hours
W0635	Situational Work Assessment, per 15 minute unit. Maximum 160 units 40 hours, over 1-3 weeks.
W0637	Transitional Work Services, per 15 minute unit. Maximum of 192 units or 48 hours
W0641	Job club, per 6 minute unit, up to 200 units in 20 weeks.
W0644	Ergonomic Study, 15 minute unit, up to 28 units or 7 hours
W0645	Job Analysis, 15 minute unit, up to 16 units or 4 hours
W0647	Automobile repairs, by report
W0648	Physical Reconditioning, Unsupervised (Y's, Spa), by report. One 3 month program maximum per claim.
W0650	Job Seeking Skills Training, face-to-face, per 6 minute unit. Up to 200 units or 20 hours
W0659	Job Development, per 6 minute unit. Up to 400 units or 40 hours in 20 weeks
W0660	Job Placement and Development, per 6 minute unit, up to 400 units or 40 hours in 20 weeks
W0662	Work Adjustment - Facility Based, per 15 minute unit. Maximum 140 units or 35 hours per week for 12 weeks

W0663	Job modification, by report
W0665	Tools and equipment, by report
W0672	Job coach, per 15 minute unit, maximum of 160 units or 40 hours
W0674	Child/dependent care, by report
W0690	Training – Books, Supplies and Testing, by report
W0691	Remedial Training, by report
W0692	Short Term Training - up to 1 year, by report
W0694	Long Term Training – over 1 year, by report
W0702	Occupational Rehabilitation - Comprehensive initial 2 hour session, 15 min unit, up to 8per day or 320 in 8 wks
W0703	Occupational Rehabilitation – Comprehensive, Each Additional Hour. 15 min unit up to 960 units in 8 weeks.
W0710	Work Conditioning, per 15 minute unit, up to 640units or 160 hours in 8 weeks
W0750	Nutritional Counseling/Weight reduction program, per hour, by R.D.
W3000	Voc rehab case manager phone calls/email to the IW or representative, surplus-funded plan, per 6 min
W3001	Voc rehab case manager phone calls/email to the physician or representative, surplus-funded plan, per 6 min
W3002	Voc rehab case manager phone calls/email to the employer or representative, surplus-funded plan, per 6 min
W3003	Voc rehab case manager phone calls/email to the BWC, surplus-funded plan, per 6 min
W3004	Voc rehab case manager phone calls/email to the MCO, surplus-funded plan, per 6 min
W3005	Voc rehab case manager phone calls/email to the service provider, surplus-funded plan, per 6 min
W3006	Voc rehab case manager phone calls/email to other (must specify), surplus-funded plan, per 6 min
W3010	Voc rehab case manager face-to-face meeting with IW or representative, surplus-funded plan, per 6 min
W3011	Voc rehab case manager face-to-face meeting with physician or representative, surplus-funded plan, per 6 min
W3012	Voc rehab case manager face-to-face meeting with employer or representative, surplus-funded plan, per 6 min
W3013	Voc rehab case manager face-to-face meeting with BWC, surplus-funded plan, per 6 min
W3014	Voc rehab case manager face-to-face meeting with MCO, surplus-funded plan, per 6 min
W3015	Voc rehab case manager face-to-face meeting with service provider, surplus-funded plan, per 6 min
W3016	Voc rehab case manager face-to-face meeting with other (must specify), surplus-funded plan, per 6 min
W3020	Documentation review by vocational rehab case manager, surplus-funded plan, per six minute unit
W3025	Initial assessment report writing by vocational rehab case manager, surplus-funded plan, per 6 min
W3030	Plan writing by vocational rehab case manager, surplus-funded plan, per 6 min
W3035	Report writing by vocational rehab case manager, surplus-funded plan, per 6 min
W3039	Labor Market Survey by vocational rehab case manager, surplus-funded plan, per 6 min
W3040	Transferable Skills Analysis (TSA) report writing by voc rehab case manager, surplus-funded plan, per 6 min
W3045	Vocational rehab case manager travel time, surplus-funded plan, per 6 min
W3046	Vocational rehab case manager wait time, surplus plan, per 6 min
W3047	Vocational rehab case manager mileage, surplus-funded plan, per mile
W3050	Other provider travel time, surplus-funded plan, per 6 min
W3051	Other provider wait time, surplus-funded plan, per 6 min
W3052	Other provider mileage, surplus-funded plan, per mile
Z0600	Voc rehab program reimbursement for injured worker travel in specific situations with contractual agreement; program reimbursed
Z0601	Voc rehab program reimbursement for injured worker meals in specific situations with contractual agreement; program reimbursed
Z0602	Voc rehab program reimbursement for injured worker lodging in specific situations with contractual agreement; program reimbursed
Z0700	Relocation expenses for injured worker in specific situations; injured worker reimbursed

H. HOME HEALTH AGENCY SERVICES

1. Eligible Providers

To be enrolled and certified by BWC, home health agencies must be either:

- Certified by Medicare; or
- Accredited by the Joint Commission;
- Accredited by Community Health Accreditation Program (CHAP); or
- Accredited through an organization granted deeming authority by Medicare.

2. Services

a. Skilled Nursing, Hourly Nursing, Home Health Aides, Therapists, and Social Workers

Billing for home health services must be submitted to the MCO on a CMS 1500 or C-19 Service

Invoice using the appropriate Level I (CPT®) codes for physical, occupational or speech therapy and

Level II or Level III HCPCS codes, listed in Chapter 2 of this manual, for other services including skilled nursing visits, hourly nursing, home health aide, and social worker visits.

*Note *Skilled nursing visits include initial assessment and up to two (2) hours/day. Thereafter, services are paid per fifteen (15) minute increments. Time documentation shall be included in all notes.*

b. Mileage and Travel Time

The following codes are specific to services provided by home health agencies.

W2704 Home health agency worker providing direct care, mileage per mile, beginning with 51st mile round trip.

W2705 Travel time, home health agency professional worker each six (6) minutes

W2706 Travel time, home health agency non-professional worker each six (6) minutes

The MCO shall select the BWC certified Home Health Agency that is closest to the injured worker's residence.

- Payment of mileage and/or travel time is limited to home health agency workers who are providing direct care to the injured worker.
- Mileage shall be reimbursed beginning with the 51st mile for a round trip for an injured worker.
- Mileage and time are calculated as follows:
 - Mileage and/or time calculation begins from home health worker's home base to IW home, and ends with return trip from IW home to home health worker's home base or next client whichever comes first; **or**
 - Mileage and/or time begins from home health workers previous point of service to IW home and ends with return trip from IW home to home health worker's home base or next client whichever comes first.

*Note *Mileage and travel time codes may not be billed in conjunction with the all-inclusive per diem home infusion therapy codes or hospice codes.*

c. Home Infusion Therapy

MCOs are required to negotiate a per diem rate for all home infusion therapy services while still maintaining high quality care for Ohio injured workers. This rate shall include nursing services, medical supplies, medication, and pharmacy services, unless otherwise noted (see iii below).

All-inclusive per diem rates may be negotiated with the following BWC certified providers:

- i. A Medicare certified or Joint Commission accredited home health agency which has its own state pharmacy board licensed fluid therapy pharmacy; or
- ii. A state pharmacy board licensed fluid therapy pharmacy which holds Joint Commission accreditation as a certified home infusion therapy provider with nurses either employed by the pharmacy or contracted by the pharmacy through a Medicare certified or Joint Commission accredited home health agency.
- iii. In some instances, it may be necessary for pharmacy services and skilled nursing services to be billed separately if a nursing agency is being used in addition to the infusion pharmacy. The pharmacy per diem charge will include all services and supplies except for skilled nursing visits. The home health agency will bill for each skilled nursing visit.

The MCOs' negotiated per diem rates are expected to be equal to or lower than the BWC fees for the individual components. Billing for home infusion therapy must be submitted to the MCO on a CMS 1500 or BWC C-19 Service Invoice. BWC recognizes the following Level III HCPCS codes for billing of home infusion therapy:

- W9010 - all-inclusive per diem, parenteral nutrition therapy;

- W9020 – all-inclusive per diem, enteral nutrition therapy;
- W9030 - all-inclusive per diem, antibiotic home infusion therapy;
- W9040 - all-inclusive per diem, pain management home infusion therapy;
- W9050 - all-inclusive per diem, fluid replacement home infusion therapy;
- W9060 - all-inclusive per diem, chemotherapy home infusion therapy;
- W9070 - all-inclusive per diem, multiple home infusion therapies;
- W9075 – home infusion therapy, includes nursing and medical supplies only.

d. Hospice Services

BWC enrolls hospice providers as Provider Type 30 - Home Health Agency. Hospices must be licensed by the state and be Medicare/Medicaid certified to become providers. Criteria for hospice services eligibility includes:

- Request for hospice care must be at physician of record (POR) direction;
- The need for hospice care must be directly related to the claim allowance;
- The injured worker must be terminally ill with an estimated life expectancy of less than six (6) months;
- Aggressive treatment is no longer occurring. All future treatment will be palliative (for the comfort of the patient).

Services should be authorized for no more than ninety (90) days at a time. All services and supplies must be provided for patient comfort rather than for treatment.

- In home hospice care that includes all services and supplies necessary for the patient's comfort – may include nursing care, counseling services, massage, art, music, bereavement therapies, and supplies.
- Respite hospice care that may be provided in hospice facilities or in nursing homes or hospitals with which the hospice provider has a contract to provide respite care.
- Acute hospice care **for pain management** in hospice facilities or in nursing homes or hospitals with which the hospice provider has a contract to provide acute pain management services.

All services and supplies are reimbursed to the hospice provider at an all-inclusive per diem rate. The per diem rate is paid regardless of the number of services or the time spent providing those services, but it is expected that all patient care needs be met by the Hospice provider. Additional home health services will not be approved. The following codes are billed to MCOs by the hospice provider and then the hospice provider is responsible for reimbursing the nursing home, hospital, etc., with which it has a contract:

- Z0500 – in home hospice care per diem
- Z0550 – respite hospice care per diem
- Z0560 – acute hospice hospital care for pain management per diem.

3. Billing Requirements

Billing for home health services must be submitted to the MCO on a CMS-1500 or C-19 Service Invoice using the appropriate Level I (CPT®), Level II, or Level III HCPCS codes.

I. NURSING HOME SERVICES

a. Eligible providers

- Nursing homes (skilled nursing facilities and intermediate care facilities) must be licensed by the State Health Department.
- For BWC purposes, sub-acute facilities and skilled nursing facility (SNF) units within a hospital are enrolled as Nursing Homes.

b. Services Provided

Services provided in the all-inclusive per diem rate include:

- Room and board;
- Personal hygiene supplies and services;

- Psychosocial services;
- Non-prescription medications;
- Laundry services;
- Maintenance therapy;
- Activity programs; and
- Equipment not used solely for the use of the injured worker.

c. Billing Requirements

Bills must be submitted to MCOs on either the CMS 1500 or C-19 Service Invoice using the appropriate all-inclusive per diem skilled nursing facility or intermediate level code found in Chapter 2.

- Nursing homes may bill separately for physical, occupational and speech therapy using CPT® codes.
- In extenuating circumstances, when the injured worker’s condition requires services and supplies over and above those reimbursed using the skilled nursing or intermediate level per diem codes, the nursing home may negotiate an all-inclusive per diem rate with the MCO.
- Often, skilled nursing facility (SNF) bills, especially when the SNF is located in a hospital, are submitted as transfers from an inpatient stay to the SNF. If the initial inpatient bill has already been paid, the SNF’s bill will deny as a duplicate. The SNF must re-submit the charges on a CMS 1500 or C-19 Service Invoice using its nursing home provider number. If a hospital does not have a separate BWC provider number for its SNF, it should contact BWC’s Provider Enrollment department at 1-800-OHIOBWC.
- Prescription medications must be billed to BWC’s Pharmacy Benefits Manager by the pharmacy providing the medications.

J. RESIDENTIAL CARE/ASSISTED LIVING FACILITIES

In order to be BWC enrolled and certified, residential care/assisted living facilities are required to have a State Health Department License. Residential Care/Assisted Living Facilities are enrolled as provider type 53 (nursing home). Level III HCPCS code, Z0180 - residential care/ assisted living facility, per diem, is used to bill for these services. The fee is all-inclusive. The MCO shall request a written copy of what is included in the bundled monthly cost and copy it to the claim.

K. TENS and NMES

The intent of this policy is to implement minimum standards for all vendors supplying TENS/NMES units to Ohio’s injured workers and to establish standardized criteria for the medical indications for the use of TENS/NMES.

Pursuant to O.R.C. 4752.02(A), no person shall provide home medical equipment services unless they have a valid license or certificate of registration from the Ohio Respiratory Care Board. This includes TENS units. All in-state BWC-certified DME providers already have the mandatory license/certificate, as this is required to obtain BWC certification. O.R.C. 4752.02 exempts from the licensure/certification requirement the following:

- Orthotists
- Prosthetists
- Predoctors
- Hospital providing home medical equipment as an integral part of patient care and not through a separate entity that has its own Medicare or Medicaid provider number from this licensure/registration requirement.

TENS: A device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient’s perception of pain by inhibiting the afferent pain nerve impulses and/or stimulating the release of endorphins.

NMES: A device which transmits an electrical stimulus to muscle groups and causes the muscle to contract.

1. Required Criteria for TENS/NMES Units

These criteria apply to all vendors supplying TENS/NMES units to Ohio's injured workers.

1. BWC Minimum Technical and Educational Criteria

i. TENS and NMES units

Requirement: Device must produce constant current.

Rationale: Constant current maintains waveform as it is driven through the skin. It allows the current to be delivered in a uniform pattern, increasing the comfort level for the patient. Breakdown of the waveform may result in increased skin irritation and burning.

ii. Electrodes

Requirements: a.) Impedance must be no greater than 75 ohms. Ideal impedance is 30-60 ohms. b.) **Re-usable electrodes** must be able to be reused 10-15 times depending on skin condition.

Rationale: a.) Increased ohms cause the need for higher current levels for maximum functioning. b.) Re-use of electrodes provides for increased efficiency and decreased costs.

iii. Instruction/Education

Requirement: TENS and NMES units supplied by a practitioner must be personally fitted and face to face instruction provided when the unit is supplied. This instruction must be documented in the patients record. TENS and NMES units provided by a DME supplier must be personally fitted and face to face instruction given by a direct employee of the DME provider within 5 business days of the request for the unit, at no additional charge. If the DME verifies and documents that the ordering practitioner is supplying the instruction/education, the DME is not required to do so. This verification documentation should be available to BWC or MCO upon request.

Rationale: Injured workers are more apt to use the TENS or NMES unit correctly and to have fewer problems and increased pain relief if given face to face instruction rather than if given written or telephonic instruction.

2. Supplies Requirement:

The injured worker's MCO shall regularly determine the specific TENS supplies needed by the injured worker throughout the period of time authorized for TENS use. The TENS provider must receive authorization from the injured worker's MCO prior to the delivery of supplies and/or equipment. The TENS provider shall then deliver the supplies and bill the injured worker's MCO after authorization is received. A self-insuring employer may, but is not required to, follow the same procedure as an MCO under this rule; provided, however, that in no event shall a self-insuring employer require a injured worker to submit a written request for TENS supplies and/or equipment. The injured worker's MCO shall retain documentation of the contact with the injured worker substantiating the injured workers need for supplies in accordance with the time frames set forth in rule 4123-6-14.1 of the Administrative Code. The TENS provider's bill must indicate the actual date of service, reflecting the date that services or supplies were provided. The bureau, MCO, QHP, or self-insuring employer may adjust bills upon audit if the audit discloses the provider's failure to comply with this rule.

The TENS provider shall maintain the following records and make them available for audit upon request:

(1) Authorizations of TENS supplies or equipment received from the injured worker's MCO, and all other documentation relating to the injured workers need for TENS supplies or

equipment received by the provider prior to the delivery of the supplies or equipment, including any requests received from the injured worker, if applicable;
(2) Records of the provider's wholesale purchase of TENS supplies or equipment; and,
(3) Records of delivery of supplies to injured workers and of the delivery or return of TENS units.

Upon request, the provider shall supply copies of the record information to the requester at no cost. Failure to provide the requested records may result in denial or adjustment of bills related to these records.

Rationale:

Appropriate amounts of medically necessary supplies will be provided. Billing provider will not issue supplies unless the injured worker's MCO has provided authorization.

c. BWC Medical Necessity Criteria

i. TENS For Chronic Pain

- Prior authorization by the bureau, MCO, or self-insured employer or their agents is required for TENS rental or purchase.
 - Payment for a transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with chronic, intractable pain who meet the following criteria:
 - Documentation of chronic pain that has been present for three months;
 - Documentation of the location of pain, duration of time patient has had pain, and the presumed cause of the pain;
 - Documentation of other modalities that have been tried and failed;
- Trial rental period of minimum of one month to determine the effectiveness of TENS unit.
- For purchase of a TENS unit for chronic pain, the following documentation must be present in the physician's records at the conclusion of the 30 day trial:
- Frequency and duration of use of TENS;
- Results of TENS units modulating pain

ii. TENS for Acute Post-operative Pain

- TENS rental is generally limited to 30 days beyond surgery. For reimbursement beyond 30 days, the physician must provide medical documentation for justification.

iii. Neuromuscular Stimulators (NMES)

- A NMES device provides an electrical stimulus directly to the muscle or motor nerve of the muscle, causing the muscle to contract. The goal is to stimulate denervated muscle to prevent atrophy or degeneration and to strengthen/train healthy muscles that are at risk of atrophy from immobilization or disuse due to injury. Prior authorization by the bureau, MCO, or self-insured employer or their agents is required prior to NMES rental or purchase.
- The MCO Medical Director or an MCO physician consultant is required to review each request for home rental or purchase of NMES based on medical necessity and BWC NMES criteria.
- Reimbursement of NMES devices for home use for the treatment/prevention of muscle atrophy requires the following conditions be met:

- The patient has suffered partial or complete loss of function in one or more muscles because of an injury to a peripheral nerve or nerve root, and
- Denervation is substantiated by EMG confirming the nerve injury. The EMG must demonstrate positive waves and/or fibrillation in the affected muscles.

- BWC/MCOs will reimburse NMES and also Functional Electrical Stimulation (FES) to enhance walking of injured workers with spinal cord injuries (SCI) who meet all the following criteria:
 - Diagnosis of paraplegia of both lower limbs (ICD-9 344.1);
 - Willingness to use the device on a long-term basis;
 - High motivation, commitment and cognitive ability to use the device for walking;
 - Completion of a physical therapy training program of a minimum of 30 sessions with the NMES unit over a 3 month period;
 - Intact lower motor units (L1 and below) both muscle and peripheral nerve;
 - Demonstration of brisk muscle contraction to NMES and sensory perception of electrical stimulations sufficient for muscle contraction;
 - Muscle and joint stability for weight bearing at upper and lower extremities with demonstration of balance and control to maintain an upright support posture independently;
 - Ability to transfer independently and demonstration of standing independently for at least 3 minutes;
 - Demonstration of hand and finger function to manipulate controls;
 - Minimum of 6-month post recovery spinal cord injury and restorative surgery; and
 - Absence of hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis
- The appropriate Level I CPT® code to be billed to MCO/BWC for the required physical therapy with the NMES unit is 97116-gait training.
- NMES/FES for walking is contraindicated for SCI injured workers with any of the following:
 - Cardiac pacemakers or cardiac defibrillators;
 - Severe scoliosis or severe osteoporosis;
 - Irreversible contracture;
 - Autonomic dysreflexia; or
 - Skin disease or cancer at the area of stimulation

2. **OAC 4123-6-43 Payment of Transcutaneous electrical nerve stimulators and neuromuscular electrical stimulators**

Payment will be approved for a TENS unit for treatment of allowed conditions in a claim directly resulting from an allowed industrial injury or occupational disease, as provided in OAC 4123-6-43 and in this manual.

- Prior authorization is required to have a prescribed transcutaneous electrical nerve stimulator unit and supplies furnished to the claimant.
- Each claimant who requires a TENS unit will be provided only one unit at a time.
- For each TENS unit request approved, the unit shall be rented for a trial period of thirty days before purchase of the TENS unit. This trial period is to evaluate the medical necessity and effectiveness of the TENS treatment.
- All rental payments for the TENS unit will be applied to the purchase price

- A TENS unit, furnished and purchased for the claimant, is not the personal property of the claimant, but remains the property of the bureau or self-insuring employer.
- At its discretion, the bureau or self-insuring employer reserves the right to reclaim and recover the TENS unit from the claimant at the completion of the course of TENS treatment.
- Once a TENS unit is purchased, the bureau or self-insuring employer will reimburse for repair or replacement, upon the submission of request from the physician of record or treating provider that includes medical documentation substantiating the continued medical necessity and effectiveness of the unit.

Note: The above criteria listed in ORC 4123-6-43 Payment of Transcutaneous Electrical Nerve Stimulators, also apply to the payment of neuromuscular units (NMES) .

3. Coding and Reimbursement of TENS/NMES

Note: BWC will not separately reimburse for a TENS/NMES fitting and instruction. Fee for TENS/NMES unit includes fitting and instruction. Please refer to the most current medical and professional provider fee schedule for reimbursement rates. Current fee schedules are published on at ohiobwc.com/provider/services/FeeSchedules.asp.

Code	Description
E0720	TENS unit, 2 lead (rent to purchase)
E0730	TENS unit, 4 lead (rent to purchase)
E0731	Form fitting conductive garment, TENS or NMES
E0735	All supplies for TENS and NMES except lead wires, per month
E0745	NMES unit (rent to purchase)
A4557	Lead wires, per pair

L. LOW LEVEL LASER THERAPY

BWC’s review of the medical literature determined there is inadequate evidence to support the medical effectiveness of LLLT for the treatment of musculoskeletal disorders. See the BWC position paper on our Web site, [ohiobwc.com /Provider/Services/Medical Position Papers](http://ohiobwc.com/Provider/Services/Medical%20Position%20Papers).

M. OTHER BWC CERTIFIED PROVIDER SERVICES

Billing from all other BWC certified providers, including, but not limited to, ambulance, durable medical equipment supplier, orthotist, prosthetist, and traumatic brain injury facility must be submitted to the MCO on a CMS 1500 or C-19 Service Invoice using the appropriate Level I (CPT®), Level II or Level III HCPCS Codes.

BWC follows HCPCS Level II to report durable medical equipment E0100-E9999. Before an item can be considered to be durable medical equipment, it must meet all the following requirements: it must be able to withstand repeated use; be primarily and customarily used to serve a medical purpose; generally not useful to a person in the absence of an illness; and appropriate for use in the home.

Requests for medical services that require prior authorization must be submitted by the physician of record or treating provider. Provider types whose signature must appear on the C-9 treatment request include all POR provider types (MD, DO, DC, DDS, DMT, DPM, psychologist), audiologist, optometrist, advanced practice nurse, physician assistant, physical therapist, occupational therapist, licensed independent social worker, and licensed professional clinical counselor. Treatment requests from any other provider type should not be processed. *Note* refer to Signature on Medical Evidence Grid .*

1. Durable Medical Equipment

Durable medical equipment is defined as equipment which:

- Can withstand repeated use;
- Primarily and customarily serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury;
- Is appropriate for use in the home; and
- Does not include disposable items.

The following reusable items are examples of DME:

- hospital beds
- mattresses for hospital beds
- walkers
- wheelchairs
- breathing machines
- crutches
- bedside commodes
- seat lift mechanism

BWC considers a seat lift mechanism to be medically necessary for an injured worker who requires a mobility aid to stand from a seated position due to physical limitations that are reasonably related to the industrial injury (disease). BWC reimburses the seat-lift mechanism, (E0627, E0628 or E0629) when the MCO determines it is medically necessary and appropriate to the industrial injury. BWC does not reimburse the chair (furniture).

Equipment which is primarily and customarily used for a non-medical purpose does not qualify as durable medical equipment and will not be reimbursed by BWC. The following items are never covered by BWC pursuant to [OAC 4123-6-07](#).

- **Home furniture** including, but not limited to: reclining chairs, non-hospital beds, water beds, lounge beds (such as Adjust-A-Sleep Adjustable Bed, Craftmatic Adjustable Bed, Electropedic Adjustable Bed, Simmons Beautyrest Adjustable Bed);
- **A mattress** for a non-hospital bed;
- **Home exercise equipment** including but not limited to such equipment as treadmills and exercise bikes;
- **Home whirlpools** including built-in whirlpools and pumps, portable hydrotherapy pools, jacuzzi tubs, portable saunas and spas, and TheraSaunas are not considered to be medically necessary. When a request is received for a built in hot tub/whirlpool, the MCO must call the provider to advise that BWC covers the “over tub whirlpool” (E1300) if determined to be medically necessary and appropriate to the industrial injury.

Specific features of durable medical equipment that have been determined by the MCO/BWC to be features that are not medically necessary or do not have a reasonable relationship to the allowed conditions in the claim will not be reimbursed by BWC/MCO. Examples include:

- BWC will not reimburse a heavy duty/bariatric piece of equipment unless the IW meets the weight requirements.
- BWC limits reimbursement of a hospital bed mattress to a single size mattress, or the size that is required by the injured worker determined by the IW’s weight, height, and medical condition. BWC does not reimburse for a double, queen, or king size mattress to accommodate two people.
- BWC will not reimburse a “deluxe” model if the standard model provides the features that are medically necessary for the IW.

BWC considers Durable Medical Equipment (DME) to be purchased when rental has reached the BWC purchase fee. 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.

2. Equipment used as part of a surgical procedure

Equipment used as part of a surgical procedure (i.e. implantable devices, surgical hardware) must be billed by the facility where the procedure takes place (i.e. ASC, hospital) or by the physician if done in the physician's office. BWC or the MCO will not reimburse the manufacturer or supplier of the equipment when the equipment is used as part of a surgical procedure. Replacement batteries for implanted devices will be reimbursed to the attending provider or DME supplier. Examples of equipment used as part of a surgical procedure include, but are not limited to: implantable neurostimulator pulse generator, implantable neurostimulator electrodes, implant hardware, implantable infusion pump and implantable intraspinal catheter.

N. SERVICES APPROVED AND REIMBURSED BY BWC RATHER THAN BY THE MCO

1. Caregiver services

- Caregivers not employed by BWC certified home health agencies who were initially approved for services prior to December 14, 1992 (January 9, 1995 for spouse caregivers) may continue providing the services if approved by BWC.
- Billing must be submitted directly to BWC rather than to an MCO.
- Caregivers should not bill dates injured worker is hospitalized as those dates are not reimbursable.
- Annual review and renewal of caregiver services authorization will be performed through the BWC service office assigned to the claim.
- Per OAC 4123-6-38.1, in the event the caregiver is no longer able to provide services, no replacement caregivers are allowed. A BWC certified home health agency must provide further services.

2. Home and vehicle modifications

When the provider submits a request for home and/or vehicle modifications, the MCO shall respond to the provider and injured worker in writing, according to C-9 processing time frames, that the request is being forwarded to the specific Catastrophic Nurse Advocate (CNA). The CNA will address all home and vehicle modification requests for all claims regardless if the equipment being requested is for a catastrophic claim and will issue a determination. The CNA will work closely with the MCO case manager and the necessary vendors to insure coordination of the services. If the MCO receives a request for other services/supplies on the same C-9, the MCO will review and respond to the non-home and vehicle modification services request within the C-9 processing timeframes.

The BWC Catastrophic Nurse Advocate is the primary authorization source for home and vehicle evaluations and modifications.

- Reimbursement of home and vehicle modification services is made by either BWC or the MCO depending upon specific service and provider type.
- Actual home and vehicle modifications are performed by a vendor, billed with a specific W code and paid by BWC.
- Other services provided by a vendor require W codes for billing. These services are paid by BWC. **Exception:** Scooter/wheelchair lift and installation (W4000 and W4001) including anchoring the lift to the vehicle or attachment of a hitch is authorized and paid by the MCO. An installation that requires additional vehicle modification requires review/authorization by BWC.
- Services billed by out-patient hospital (driving evaluations and driving training) require the use of revenue codes with appropriate CPT codes and are paid by the MCO.
- Services billed by in-patient hospital require revenue codes only and are paid by the MCO.

The list below outlines specific billing, coding, and reimbursement information:

Description of Service	Provider Type	HCPCS/CPT® Code	Revenue Code	Fee	Billing form	Bill To
Driving evaluation PT, OT or certified	Non-facility	W0500	NA	By report (BR)	C-19 or CMS 1500	BWC

driving instructor

Driving evaluation	Facility Outpatient	97003	OT	Hospital's outpatient reimbursement rate*	UB-92	MCO
Driving evaluation	Facility Outpatient	97001	PT	Hospital's outpatient reimbursement rate*	UB-92	MCO
Driving instruction for modified vehicle- PT, OT or certified driving instructor	Non- facility	W0549	NA	By Report (BR)	C-19 or CMS 1500	BWC
Driving instruction for modified vehicle	Facility Outpatient	97535	PT	Hospital's outpatient reimbursement rate*	UB-92	MCO
Driving instruction for modified vehicle	Facility Outpatient	97535	OT	Hospital's outpatient reimbursement rate*	UB-92	MCO
PT/OT evaluation for home/vehicle modification	Non- facility	W0678	NA	By Report (BR)	C-19 or CMS 1500	BWC
PT evaluation for home/vehicle modification	Facility Inpatient	NA	PT	Hospital's inpatient reimbursement rate*	UB-92	MCO
OT evaluation for home/vehicle modification	Facility Inpatient	NA	OT	Hospital's inpatient reimbursement rate*	UB-92	MCO
Home Modification (includes permanent ramp)	Vendor	W0675	NA	By Report (BR)	C-19 or CMS 1500	BWC
Vehicle Modifications	Vendor	W0679	NA	By Report (BR)	C-19 or CMS 1500	BWC
Home and Vehicle Modification Repairs	Vendor	W0677	NA	By Report (BR)	C-19 or CMS 1500	BWC
Portable Ramp Rental or Purchase	Vendor	W0676	NA	Current Fee Schedule	C-19 or CMS 1500	BWC
Lift, vehicle, 3-4 wheeled chair, with manual swing;	Vendor	W4000	NA	Current Fee Schedule	C-19 or CMS 1500	MCO

Lift, vehicle, 3-4 wheeled chair, with motorized swing	Vendor	W4001	NA	Current Fee Schedule	C-19 or CMS 1500	MCO
---	---------------	--------------	-----------	-----------------------------	-------------------------	------------

In order to differentiate between the types of scooter lifts that are available, BWC established the following codes:

- W4000: Lift, vehicle, 3-4 wheeled chair, with manual swing
- W4001: Lift, vehicle, 3-4 wheeled chair, with motorized swing

BWC will not reimburse a “deluxe” model of a scooter lift if the standard model provides the features that are medically necessary for the IW.

The MCOs have been advised that the customer rebate offered by several auto manufacturers when a lift or ramp product is purchased with an eligible new vehicle should be applied to the purchase of the scooter lift. The MCO will deduct the amount of the rebate from the established fee for the lift and installation.

a. Non-Covered Services include:

- Swimming pools of any type
 - Hot tubs portable, freestanding or installed
 - Spas portable, freestanding or installed
 - Whirlpool baths portable, freestanding or installed*
 - Jacuzzis portable, freestanding or installed
 - Central air conditioning or air-purification systems
 - Dismantling of constructed ramp
 - Removal, dismantling or transfer of home modifications
 - Reimbursement of routine maintenance contracts
 - Home improvements which are of general utility, and are not of direct medical benefit to the injured worker (i.e. carpeting, roof repair)
- *Note: A portable whirlpool device that is placed in the IW’s tub can be approved/reimbursed by the MCO as DME if medically necessary and related to the allowed claim condition.

b. Home Modifications

- BWC will reimburse home modifications specifically needed by the IW due to physical limitations due to the result of allowed claim conditions.
- BWC’s fee cap for home modifications is \$40,000.
- BWC will authorize home modifications on a one-time basis only. An exception would be for a ramp, which must be replaced if deterioration has occurred.
- Home modifications will be limited to the interior of a residence with exception of ramps, lifts, and platforms necessary for accessing and exiting the home. The residence to be modified must be owned by the injured worker or a member of the injured worker’s immediate family
- Bathroom: Only one bathroom will be modified. Contact BWC Catastrophic Nurse Advocate (CNA) for specifics.
- Kitchen: BWC may approve limited kitchen modifications for injured workers who are living alone. Contact BWC Catastrophic Nurse Advocate (CNA) for specifics.
- Driveway/Sidewalk – BWC does not widen driveways to allow injured workers to drive up and get out of a vehicle. BWC may approve paving of an area of a driveway or sidewalk for providing an operable surface for a scooter or wheelchair.
- Air conditioning/air purifying systems: a physician review of the claim file may be completed to determine medical necessity. Pulmonary function studies are considered when the injured worker has an occupational disease affecting the cardiovascular or respiratory system. Quadriplegics may require a room air conditioner for body temperature consistency. If an injured worker desires central air conditioning for the entire home, BWC will reimburse the percentage of cost for air conditioning for the IW’s room only. BWC will authorize a room air conditioning unit. BWC does

not reimburse central air conditioning for the whole house. Air purifiers should be the portable type. Only claims allowed for pulmonary conditions, quadriplegia and burns qualify for air conditioners and only claims with pulmonary conditions for air purifiers.

- Handicap accessible home – If the injured worker chooses to purchase a new handicap accessible home, BWC will reimburse limited amounts for items such as a special shower, widened doorways, ramps, etc. An itemized list of handicapped accessories should be obtained from the builder and submitted for review and authorization prior to purchase. Reimbursement will be made after the house is built and the injured worker furnishes a copy of the deed/closure documentation showing ownership.
- Elevator or stair-lift – A stair-lift can be approved for an injured worker on an individual case-by-case basis, for example, in cases where the injured worker is unable to climb stairs and bathroom facilities are on the second floor. If an injured worker receives a stair-lift, a second manual wheelchair may be approved. It may be less expensive to provide a first floor bathroom rather than to install an elevator if the residence structure will not accommodate a stair-lift. **Elevators should only be approved when there are no other alternatives.** Stair-lifts are not approved for basement access.
- Ceiling installed lift tracking mechanism – The injured worker must ensure that the home structure can accommodate this equipment.

c. Vehicle Modifications

BWC requires a physician prescription or BWC Form C-9 from the POR for vehicle modifications and driving evaluation and training (if needed), stating medical necessity and the relationship to the allowed condition. A complete driving evaluation for initial vehicle modifications by a certified driving instructor is also required.

- A vehicle modification will be considered by the CNA no more frequently than once every five (5) years. A more frequent or additional modification to the vehicle may be considered only if medical documentation supports a change in the injured worker's medical condition and justifies the need.
- BWC will modify one vehicle only. The same vehicle will be modified for the lifetime of vehicle. If an injured worker owns more than one vehicle, he/she is responsible for modification of any additional vehicles.
- The IW must undergo a driving evaluation if the vehicle is to be driven by the IW. BWC may require a second driving evaluation if there is a change in the injured worker's condition.
- BWC will limit reimbursement to modification/ equipment specifically needed by the IW. BWC will not authorize luxury items. However, since quadriplegics cannot regulate their own body temperature and the atmosphere must be kept at a steady temperature, BWC may approve rear air conditioning and rear heat.
- BWC may authorize vehicle modifications for injured workers who utilize manual wheelchairs. Objective medical documentation must support the request.
- BWC may authorize hand controls or left foot gas pedal for injured workers who utilize canes, crutches, or prostheses for mobility if objective medical documentation supports the need and driving evaluation recommends.
- BWC will not pay for purchase of the vehicle to be modified.
- BWC may authorize manual wheelchair carriers (car topper) for paraplegics who can transfer.
- BWC may authorize modifications for allowed conditions requiring a power wheelchair for mobility, or when the transfer of the injured worker is impossible to accomplish independently.
- BWC will reimburse for reasonable vehicle modification repairs, not routine maintenance of modified vehicles.
- The IW is responsible for a yearly maintenance on lifts or mechanical parts.
- Repairs of \$250 or less do not require prior authorization by the BWC CNA.
- Repairs with an estimated cost greater than \$250 require authorization by BWC's CNA in advance unless done in emergency situation.

3. Prosthetics/Artificial Appliances

All eligible prosthetics/artificial appliances and repair thereof, whether for state fund claims or self-insured claims, are paid from the surplus fund. **For MCO managed claims;** the MCO receives the C-9 request for authorization, approves or denies the request. If the request is approved the provider submits the bill to the MCO. **In Self-Insured claims;** BWC is responsible for processing requests for prosthetics and travel expenses associated with the prosthetic in **all SI claims**. When a prosthetic device is needed in an SI claim, the physician/provider will send a request for the prosthetic and/or request for repair, as well as the subsequent bills, to the appropriate BWC Customer Service Team. The BWC Customer Service Team must submit the bill from the provider to Medical Billing and Adjustments.

Providers shall ensure that the following information is available for processing an artificial appliance request. Processing may be delayed if the following information is not included with the request:

1. Written evidence that an artificial appliance has been determined to be medically necessary for the injured worker from one of the following:
 - a. The Ohio State University hospital amputee clinic;
 - b. The Rehabilitation Services Commission;
 - c. An amputee clinic approved by the administrator or the administrator's designee;
 - d. A prescribing physician approved by the administrator or the administrator's designee.
2. Dated and signed prescription of the item being requested including the manufacturer, brand name and model number;
3. Recent physical examination that includes a functional assessment with current and expected ability, impact upon activities of daily living, assistive devices utilized and co-morbidities that impact the use of the prescribed artificial appliance;
4. Clinical rationale for requested artificial appliance, replacement part(s) or repair(s) and a description of any labor involved;
5. Coding description for the artificial appliance or repair utilizing the healthcare common procedure coding system (HCPCS). If a miscellaneous code is requested, all component items bundled in the miscellaneous code shall be listed along with a complete description and itemization of charges;
6. Copy of the manufacturer's price list for items requested under a miscellaneous HCPCS code; and
7. Copy of any warranties related to the requested artificial appliance.

It is the prosthetist's responsibility to assure that any prosthetic device fits properly for three months from the date of dispensing. Any modifications, adjustments or replacements within the three months are the responsibility of the prosthetist who supplied the item and BWC will not reimburse for those services. The provision of these services by another provider will not be separately reimbursed.

4. Interpreter Services

It is the policy of BWC to provide necessary and appropriate interpreter services to an injured worker. Interpreter services are utilized for expediting treatment in catastrophic claims, purposes related to the filing or investigation of the claim, purposes related to the allowed conditions in the claim, or medical specialist consultants requested by the physician of record or treating physician and approved by the managed care organization.

ASL interpreters will be provided (as necessary and appropriate) for routine office visits with the treating physician, meetings with durable medical equipment suppliers and during physical or occupational therapy. Foreign language interpreters will not be provided for the above services and no interpreters will be provided for hospital based services, unless, after the CSS or DMC staffs the case with Claims, Medical or Rehab policy, an unusual situation exists which makes providing an interpreter necessary and appropriate.

Frequently, the injured worker will arrange interpreter services from a friend, family member or other community resource. In some situations, an interpreter with special skills may be most appropriate (e.g., when the provider needs to relay complex medical information). If the

IW is not able to arrange a friend, family member or community resource to interpret, or the arrangement does not appear adequate for the circumstances, the need for an interpreter must be addressed as soon as possible with the MCO. The MCO will refer the need to the assigned CSS, or DMC, who in consultation with the MCO, will determine what is “necessary and appropriate”. The CSS or DMC shall make the arrangements for an interpreter and notify the parties to the claim and the service provider of the approval or denial of interpreter services and the specific arrangements.

To request an interpreter contact the MCO, CSS or DMC. The assigned CSS or DMC is responsible for reviewing and approving interpreter services.

Interpreters for Hospital-Based Services

Interpreter services in a hospital-based setting are the responsibility of the hospital. If the IW has been approved for hospital-based services and the CSS or DMC is aware that interpreter services will be required, the CSS or DMC may notify the hospital social services or other department designated for obtaining interpreters of the need. In an effort to prevent interruption of care and facilitate return to work, the CSS or DMC may also request that the hospital notify him or her if interpreter services will be required soon after the IW is discharged.

Interpreters for Vocational Rehabilitation

When an injured worker is participating in vocational rehabilitation and it appears interpreter services will be required, the vocational rehabilitation case manager, MCO designee and DMC must staff the plan in advance. The DMC has the responsibility to approve or disapprove the services prior to plan implementation. Critical stages in the rehabilitation process when an interpreter may particularly be needed is during the initial interview with the injured worker, during discussion of and signing of the rehabilitation agreement, when the plan expectations are discussed with the injured worker, and if and when there is a change in the case direction.

Payment for Interpreter Services

Family members, friends, medical, health care and vocational providers and/or community volunteers may provide interpretation for IWs but are not eligible for enrollment or to receive reimbursement.

BWC’s Medical Billing and Adjustments

BWC Medical Billing and Adjustments (MB&A) must verify approval of all interpreter services (BWC & IC) before processing the bill. Interpreter services that are not approved by BWC or the IC will be denied for reimbursement using EOB 353, “Payment is denied as prior authorization is required for this service.”

Billing Instructions, Codes and Fees

Current fees can be found on BWC's Web site at <https://www.bwc.ohio.gov/provider/services/agreement.asp>. BWC providers are expected to bill their usual and customary rate. Reimbursement will be at the provider billed amount or at the BWC fee, whichever is lower. Inquiries about unresolved billing issues should be directed to BWC’s Provider Contact Center at 1-800-644-6292.

Bills must be submitted on BWC’s C-19 Service Invoice that can be found on BWC’s website <https://www.bwc.ohio.gov/bwccommon/forms/BWCForms/nlbwc/ProviderForms.asp>. Instructions for completing the form can also be found in chapter 4 of this manual.

All Interpreter Services (BWC or IC) must be billed with the appropriate code(s) listed below on a C-19 Service Invoice (C-19).

- **W1930** Interpreter Services, per fifteen (15) minutes.

- **W1931** Interpreter Wait Time, per six (6) minutes, Maximum of 30 minutes per date of service (including waiting for an IW that does not show up for appointment).
- **W1932** Interpreter Travel Time, per six (6) minutes (including travel time for an IW that does not show up for appointment).
- **W1933** Interpreter Mileage, per mile.

Enrollment of Providers of Interpreter Services

Providers delivering Interpreter Services for BWC/IC approved services will be enrolled as provider type 99 (other). When an MCO requests enrollment of the interpreter, the MCO must include the vocational rehabilitation plan approved by the BWC DMC with a non-certified enrollment form. Providers of Interpreter Services may enroll using the Medco-13A Form found on the Web site at <https://www.bwc.ohio.gov/bwcccommon/forms/BWCForms/nlbwc/ProviderForms.asp>.

5. Catastrophic Case Management Plan (previously called Life Care Plan)

The Health Partnership Program places emphasis on a consistent, cooperative approach to catastrophic case management by Managed Care Organizations (MCOs) and BWC. Each catastrophic claim is different, which necessitates highly individualized management.

Catastrophic Case Management Plan (CCMP) shall be considered and reviewed with the BWC catastrophic nurse advocate (CNA) for appropriateness on catastrophic claims that are chronic and result in a disabling condition greater than one year. A CCMP is not appropriate for IWs residing in assisted living facilities, nursing homes or TBI facilities as there is usually a plan of care developed by the facility. CCMPs are to be used as tools to assist in the ongoing medical management of a catastrophic injury.

A Catastrophic Case Management Plan (which is distinct from the legally required plan of care) is to address the long-term needs of severely disabled injured workers. It is necessary to consider the needs of injured workers' family members; however, family members are not part of the workers compensation claim. The MCO Catastrophic Case Management Program Coordinator (CCMPC) and/or the CNA should staff family members' concerns and may discuss them with the employer to see if the employer is willing to pay for crisis intervention.

The MCO's Catastrophic Claim Program Coordinator and the assigned BWC CNA determine the necessity for a CCMP. The MCO shall research if a prior Life Care Plan exists for litigation purposes and adapt such a plan for BWC purposes. All conditions allowed in the claim shall be addressed on the CCMP and must contain the current status of the allowed condition or must indicate that the allowed condition has completely resolved as of a certain date.

The BWC CNA must approve the need for a CCMP and will document the need in V3. Once the need for a CCMP has been approved, the MCO will be notified by E-mail. The MCO must contract with a BWC certified provider within 60 days. It is important that the MCO's Catastrophic Claim Program Coordinator selects and instructs the provider and works closely with him/her to insure that a quality, timely CCMP is provided. The MCO also must inform the provider of the name of the BWC CNA that is assigned to the claim.

The CCMP must be completed within 60 days of referral from the MCO to the provider.

The CCMP shall include at the beginning of the report that **all services in the plan are subject to BWC/MCO policy and based upon medical necessity**. The provider writing the CCMP shall work with the BWC CNA and the MCO and be familiar with the unique differences required for providing a CCMP. All CCMPs must be reviewed with the CNA before they are discussed with the IW or the IW's family and before implementation.

The CCMP is part of the cost of the claim and is charged to the employer's risk (i.e., the employer's experience), not to the Surplus Fund. **Effective 07/01/2004, The CCMP must be billed using Level III HCPCS code Z1000 at \$100.00 per hour, not to exceed \$4,000.00. The CCMP shall be billed one time only, using the completion date as the date of service.**

To become a BWC certified LCP, the person must possess at least one of the following credentials and will be enrolled as a provider type 76;

- Certified Occupational Health Nurse (COHN);
- Certified Rehabilitation Counselor (CRC);
- Certified Insurance Rehabilitation Specialist (CIRC);
- Certified Vocational Evaluator (CVE);
- Certified Rehabilitation Nurse (CRRN);
- Certified Case Manager (CCM); and/or
- Certified Disability Management Specialist (CDMS)

These credentials alone do not automatically qualify a provider to complete a CCMP. The MCO shall be responsible for choosing a BWC certified provider that is a certified LCP or has experience developing quality LCPs. The MCO should discuss with the provider the details of the CCMP, as found in the MCO Policy Reference Guide, prior to the start of the plan.

O. EXPOSURE OR CONTACT WITH BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS WITH OR WITHOUT PHYSICAL INJURY

Requirements for the allowance and billing of an exposure claim with BWC are set forth below.

Reporting: Providers report exposure incidents on the FROI to the assigned MCO or online at www.ohiobwc.com as they would any other workplace incident for a state fund claim.

- To assist BWC with identifying these claims, providers or MCOs should indicate "ALLEGED EXPOSURE to BLOOD or BODY FLUID" in the Description of Accident section when completing the FROI.

1. Exposure Claim Processing

Except as noted for SB 223 Exposure Claims (discussed below), BWC reviews exposure claims in the same manner as all other claims.

- For the claim to be allowed, the injured worker must have suffered a physical injury from the workplace exposure **or** contracted a disease from the workplace exposure.
- Claims for exposure to blood or other potentially infectious materials only (through spit in the eye, urine splash on the body surface, blood on the skin, air-borne material) without a physical injury are non-compensable.

- a. Exposure Claims With Allowed Physical Injury:** If the claim is allowed for a physical injury (e.g. needlestick, cut or open wound etc.), BWC will assign open wound codes 870 through 893 according to the specific body part that was injured. The exposure to blood or OPIM is never allowed.

Bill Processing for Allowed Claims: The provider shall submit bills for testing, counseling, prophylactic treatment and any required ongoing testing, counseling and treatment to the MCO.

- BWC will pay for the costs of conducting post exposure medical diagnostic services to investigate whether the injured worker contracted an occupational disease from contact with blood or body fluid from the incident. Additionally, BWC will reimburse the costs of related preventive treatment in accordance with OSHA and the Centers for Disease Control and Prevention (CDC) exposure treatment protocols.
- If OSHA/CDC guidelines require individual counseling, providers may use Preventive Medicine Individual Counseling CPT® codes 99401 through 99404 when billing for these services.

Subsequent Development of a Disease: If a worker contracts a disease after being exposed at work and the claim was allowed, the worker may file a request to additionally allow the disease as an occupational disease in the existing claim, or may file a new claim.

- b. Non-Allowed Exposure Only Claims:** If the exposure claim request contains no physical injury, the BWC order will state that the claim is disallowed due to no physical injury. BWC will assign ICD-9 code 994.9 "effects of other external causes" and identify the exposure as blood/OPIM.

- The employer may be responsible for payment of bills according to OSHA guidelines. See www.OSHA.gov or Ohio Bureau of Occupational Safety & Health, Division of Labor & Worker Safety for further information and guidelines.

Bill Processing for Non-Allowed Claims: Bills submitted to MCOs shall be rejected and returned to the provider (the MCO keeps a copy of the rejected bill).

Subsequent Development of a Disease: If a worker contracts a disease after being exposed at work without a physical injury and the claim filed was not allowed, the worker may file a new claim. The claim may be allowed for the disease as an occupational disease claim.

Federal Occupational Safety and Health Administration (OSHA) in many cases requires employers to pay for all costs associated with exposure to blood or other potentially infectious materials (OPIM), regardless of the presence or absence of a physical injury.

2. SB 223 Exposure Claims (R.C. 4123.026)

BWC or a self-insuring public employer will pay for post-exposure medical care for peace officers, firefighters, or emergency medical workers regardless of whether the worker sustains a physical injury if the peace officers', firefighters', or emergency medical workers' contact with another person's blood or body fluid:

- Occurred in the course of and arising out of employment, or when responding to an inherently dangerous situation in accordance with the conditions specified under R.C. 4123.01(A)(1)(a), and
- Occurred through any of the following means:
 - Splash or spatter in the eye or mouth, including when received in the course of conducting mouth-to-mouth resuscitation;
 - A puncture in the skin;
 - A cut in the skin or another opening in the skin such as an open sore, wound, lesion, abrasion, or ulcer.

If the peace officer, firefighter, or emergency medical worker is splashed with another person's blood or body fluid on skin that is intact (does not have an open wound, sore, puncture, etc.), medical care will not be paid by BWC or the Self Insuring (SI) Employer.

SB 223 exposure claims do not include exposure to air-borne diseases. R.C. 4123.026 specifically states that a peace officer, firefighter, or emergency medical worker must come into contact with the blood or other body fluid of another person through one of the means set forth above.

a. Covered Workers:

- "Peace Officer" means be a sheriff, deputy sheriff, marshal, deputy marshal or member of an organized police department. Peace Officers will generally work for city, county or state public employers and they are not limited to "traditional" law enforcement officers. Certain park rangers, tax and liquor agents, officers of metropolitan housing authorities or transit authorities, and others are also considered peace officers. For more detail, refer to Section 2935.01 of the Revised Code or contact the Legal Operations department if there is a question.
- "Firefighter" means a firefighter, whether paid or volunteer, of a lawfully constituted fire department.
- "Emergency medical worker" means a first responder, emergency medical technician-basic, emergency medical technician-intermediate, or emergency medical technician-paramedic, certified under chapter 4765 of the Revised Code, whether paid or volunteer.

b. Claim and Bill Processing

- 1) **SB 223 Claims With Allowed Physical Injury:** If there is a physical injury in an SB 223 claim, the claim may be allowed. If allowed, bill processing follows the procedures set forth above for bill processing of allowed exposure claims. (See M.1.a.)

- 2) **SB 223 Claims Without Allowed Physical Injury:** If there is no physical injury but the requirements of SB 223 are met, the claim will be denied. However, BWC or the SI employer will pay for the costs of conducting post exposure medical diagnostic services to investigate whether the injured worker contracted an occupational disease from contact with blood or body fluid from the incident. Additionally, BWC will reimburse the costs of related preventive treatment in accordance with OSHA and CDC exposure treatment protocols.
 - The MCO shall not inappropriately reject bills upfront. MCOs price the bill at \$0.00, attach EOB 256 (claim is disallowed), and submit the bill to BWC.
 - BWC will flag these claims for manual bill processing to permit payment even though the claim has been disallowed. BWC will review each bill and apply the necessary EOBs, including EOB 879: Payment Being Made in a Disallowed Claim for Testing or Other Services due to Alleged Exposure (SB233).
 - 3) **Non-SB 223 Air-borne Exposure Claims:** If there is an air-borne exposure (such as Tuberculosis, Whooping Cough, and/or Meningitis or other infectious disease) and no physical contact with blood or body fluid and no physical injury, the claim will be denied. No medical bills will be paid.
- c. Subsequent Development of a Disease:** If a SB 223 worker contracts a disease after being exposed at work and the claim was allowed for a physical injury, the worker may file a request to additionally allow the disease as an occupational disease in the existing claim, or may file a new claim. If the claim was not allowed, the worker may file a new claim. The claim may be allowed for the disease, as an occupational disease claim.

P. CHRONIC PAIN

Requirements for chronic pain programs to obtain BWC certification are in OAC 4123-6-02.2 (C) (12), which states: Comprehensive pain management services program (free standing) CARF accreditation; (hospital based) CARF or The Joint Commission accreditation.

Chronic pain programs must include all of the following overall objectives:

- Improve general physical conditioning in order to achieve return to work readiness, if appropriate;
- Improve overall function for return to work readiness, if appropriate;
- Increase comfort/decrease pain rating by use of pain management skills;
- Decrease dependency on the health care system;
- Identify/clarify vocational goals; if appropriate;
- Reduce inappropriate use of narcotics and other medications that may cause dependence or addiction.

In order to be considered for a chronic pain management treatment program, the IW must receive authorization for and must undergo a comprehensive multidisciplinary evaluation that includes:

- medical history and physical/neuromuscular examination to include review of medications;
- review of past, pertinent medical records;
- psychological evaluation;
- physical therapy evaluation;
- occupational therapy evaluation;
- cardiac stress test, if necessary; and
- specialist consultation(s) as necessary.

Injured worker eligibility indicators include:

- Injured worker is symptomatic of excessive pain behaviors disproportionate to the compensable injury or condition.
- Injured worker has not responded to traditional medical treatment or to an extended course of individual therapy modalities. If an injured worker has not responded to traditional medical treatment or to an extended course of individual therapy modalities, it is recommended that the

injured worker be referred to a BWC certified multidisciplinary pain management program for evaluation to determine appropriateness for entrance into the program. The ideal period for referral is six months to three years post injury, but referrals should not be limited to those time frames.

- Injured worker's use/abuse of alcohol or drugs is not so excessive that it is likely to interfere with full participation in the program.
- Injured worker is not currently experiencing any acute medical problems, is not anticipating any medical or surgical intervention and is considered medically stable to participate in a multidisciplinary, physically challenging program.
- Injured worker has previously completed no more than one multidisciplinary pain management program.
- Injured worker is demonstrating significant emotional distress as a result of the allowed injury, such as depression, anxiety or impaired interpersonal, familial, occupational or social functioning; however psychological dysfunction is not so severe as to interfere with full program participation.
- Injured worker has expressed interest and desire to participate in a chronic pain management program with a goal of returning to work, if appropriate. If no return to work goal exists, there must be an expectation of documentable cost savings through decreased reliance on health care resources as a result of participation in the program.
- Diagnosis allowed in the claim may be, but is not limited to ICD-9 chronic pain diagnoses listed:
 - 719.4 - pain in joint (fifth digit identifies body part)
 - 307.89 - other psychalgia or pain disorder associated with both psychological and general medical condition
 - 337.21 – Complex regional pain syndrome type I (CRPS) formerly Reflex sympathetic dystrophy (RSD), upper limb
 - 337.22 - Complex regional pain syndrome type I (CRPS) formerly Reflex sympathetic dystrophy (RSD), lower limb
 - 354.4- Complex regional pain syndrome type II (CRPS) formerly Reflex sympathetic dystrophy (RSD), upper limb
 - 355.71- Complex regional pain syndrome type II (CRPS) formerly Reflex sympathetic dystrophy (RSD), lower limb
 - 724.6 - chronic lumbosacral sprain/strain (already allowed for lumbar/lumbosacral sprain/strain)
 - 722.8* - postlaminectomy syndrome (fifth digit identifies back level)
 - 729.1 - fibromyalgia

Inpatient programs are appropriate only when the injured worker's condition is such that a highly supervised and monitored program is essential for success. One or more of the following criteria must be met in order for an inpatient program to be approved.

- IW requires weaning from prescribed medication before any possible benefit of the pain management program can be realized.
- IW exhibits personality/behaviors such that effective participation would be unlikely in an unsupervised/unmonitored setting.
- IW needs a structured environment for psychological support and/or medical monitoring.
- IW's pain behaviors are reinforced in the home to the point that it is necessary for the IW to be removed from the home in order to effectively succeed in a pain program.

Outpatient programs are appropriate when the injured worker's condition does not warrant the highly supervised environment of an inpatient program. Outpatient with lodging may be warranted if the IW resides more than twenty-five (25) miles from the chronic pain program facility or the IW is involved in dysfunctional home, family or relationship that contributes to and exacerbates pain behaviors. Outpatient without lodging is appropriate if the IW resides within twenty-five (25) miles or less of the pain program facility, has a supportive home/family structure, does not significantly rely on medication, and does not use illicit drugs or misuse alcohol.

Services provided by a chronic pain program must be billed with the appropriate per diem code with the exception of the following services that may be billed separately:

- physician services;

- psychologist services;
- physical therapy or occupational therapy services **not included in the scheduled pain management program**

For services billed separately from the chronic pain program, the 11-digit BWC provider number or National Provider Identifier (NPI) of the **individual treating practitioner** must be included on the CMS 1500 and the 11-digit BWC provider number or NPI of the **group practice** or facility to whom the payment is to be made must be entered on CMS 1500. See Chapter 4 for detailed billing instructions.

Chronic pain program per diem codes include:

- W1000 CARF accredited or BWC certified chronic pain program, per day
- W1001 CARF accredited or BWC certified chronic pain program pre-admission evaluation
- W1002 CARF accredited or BWC certified chronic pain program, per half day (four hours or less)

The following local Level III HCPCS procedure codes are used when the chronic pain program (billing facility) has a contractual agreement with other facilities to provide travel, meals, and or lodging to the injured worker:

- Z0600 Vocational rehabilitation or chronic pain program, not claimant reimbursement, travel
- Z0601 Vocational rehabilitation or chronic pain program, not claimant reimbursement, meals
- Z0602 Vocational rehabilitation or chronic pain program, not claimant reimbursement, lodging

For chronic pain program per diem billing and billing the level III codes to provide travel, meals and or lodging in a chronic pain program, the 11-digit BWC provider number or NPI of the group practice or facility to whom the payment is to be made must be included on the CMS 1500.

1. Drug Screens

Urine drug tests (UDTs) may be done to ensure appropriate use of opioids in the treatment of chronic pain. UDTs may be done without prior authorization from the MCO; however, the provider must assess the injured worker's level of risk and submit it to the MCO prior to determining the appropriate number of UDTs to authorize. The risk assessment is a part of the standard evaluation and management of the IW. It is NOT appropriate for a provider to schedule an appointment with an IW for the sole purpose of completing a risk assessment and then bill under an evaluation and management code (e.g., preventative medicine, psychiatric diagnostic and psychological codes). BWC shall not pay for a separate service to conduct a risk assessment.

BWC will reimburse for the following number of UDTs:

- Up to four UDTs yearly as determined by the injured worker's individual risks;
- Up to two additional UDTs yearly when the provider documents demonstration of aberrant behavior by the injured worker.

BWC will reimburse for UDTs meeting the following criteria:

- Performed in CLIA-certified (Clinical Laboratory Improvement Amendments) laboratories;
- Collected following a chain of custody (COC) protocol. ***Note**, the COC form must be submitted to the MCO certifying that the specimen collection followed a COC collection protocol.
 - BWC allows autonomy for each provider to decide what COC form to use or to create one, but the form must contain the following elements:
 - Injured worker's name, address, phone number, DOB, signature and claim number;
 - Collection site name, address, phone number and fax number;
 - Collectors printed name, signature, date and time of collection;
 - Reason for the test (e.g., random, reasonable suspicion, follow-up);

- Documentation that the specimen temperature range was between 90-100 degrees within four minutes of collection;
 - Name of delivery service to whom the specimen was released;
 - The printed name, signature and date of the receiving lab employee;
 - Acknowledgement from the receiving lab that the specimen bottle was received with the seal intact and the injured worker's initials present on the seal;
 - Specimen results (i.e., negative or positive and for which substances);
 - If the specimen is rejected for testing, documentation from the lab detailing the reason (e.g., adulterated, substituted, broken seal).
- Billed under the following codes:
 - G0434 moderate complexity testing, per patient encounter;
 - G0431 high complexity testing, per patient encounter;
 - 80102 confirmation testing, each procedure. *Confirmatory* testing either qualitative or quantitative shall be billed under CPT 80102 and only one time for each positively identified drug within a specimen. The rationale for this is that when one quantifies the specimen, confirmation of the presence or absence of the drug occurs.
- Collected as a standard drug panel immunoassay test that includes:
 - Amphetamines;
 - Opiates;
 - Cocaine;
 - Benzodiazepines;
 - Barbiturates;
 - Oxycodone;
 - Methadone;
 - Fentanyl;
 - Marijuana; and
 - Hydrocodone.
- Collected to conduct quantitative testing for an individual drug that the IW is prescribed which is not included in the standard drug panel;
- Collected to conduct additional tests for drugs not included in the standard panel when:
 - The injured worker is prescribed the drug; and/or
 - The physician deems the testing medically necessary.
- Performed at the point-of-care when medical documentation identifies an immediate need;
- Collected for drug confirmation by gas chromatography, mass spectrometry or high-performance lipid chromatography solely for the drug in question when the immunoassay results are positive or when:
 - An unexpected drug or its metabolites are identified;
 - The prescribed drug or its metabolites are not identified in the UDT.
- Collected immediately prior to the initiation of opioid therapy for chronic non-cancer pain or for the extension of opioid therapy beyond the acute phase (e.g., a patient has been on opioids for the treatment of an acute injury for six weeks or more and the practitioner is considering opioids for chronic pain);
- Collected while a patient is on opioid therapy for chronic non-cancer pain to:
 - Verify compliance with the treatment regimen; and/or
 - Identify undisclosed drug use and/or abuse.

Note: BWC will continue to deny reimbursement of drug screens performed by employers or drug screening of injured workers performed in the emergency room at the time of injury.

Q. UTILIZING PRESCRIPTION MEDICATION FOR THE TREATMENT OF INTRACTABLE PAIN

The purpose of this policy is to provide to Ohio physicians treating Ohio Injured Workers, Bureau of Workers' Compensation (BWC) personnel, BWC Managed Care Organizations (MCOs), BWC's Disability Evaluators Panel (DEP) drug file reviewers and independent medical examiners, and injured workers, their employers and their respective representatives:

- The rules for prescribing narcotic medication in the treatment of intractable pain according to The State Medical Board of Ohio Administrative Code Chapter 4731-21;
- The expectations of the type of medical evaluation and documentation necessary to support and facilitate using prescription medication for the treatment of intractable pain in injured workers in the Ohio Workers' Compensation System;
- The key elements that may be necessary in the claim file to assist BWC personnel and physicians performing reviews to determine whether the use of prescription medications in the claim meet statutory requirements;
- The rationale and process for BWC claims management personnel to use to obtain when necessary the information needed to support or deny the use of prescription medications for the treatment of intractable pain and to facilitate the use of prescription medication when necessary and appropriate for treatment, obtain necessary information when insufficient information is lacking in the claim file, and to deter use of prescription medications when there is lack of proof of medical necessity and appropriateness.

Issues important to Ohio Workers' Compensation include:

- Lack of strict claims management guidelines regarding criteria to support use or to deny authorization of prescription medication in the treatment of intractable pain.
- Concern for overuse and excessive prescribing of prescription pain medication for some injured workers has been identified by BWC personnel, pharmacists, physicians, employers, and other parties as it impacts well being of the injured worker, potential for inappropriate use and distribution, social implications, and financial costs to the system.
- Variance in interpretation and application of The State Medical Board of Ohio Administrative Code Chapter 4731-21 by physicians performing claims management services for BWC and BWC personnel which ultimately impacts authorization/denial decisions regarding use of prescription medications.
- Lack of use of prescription medication, particularly opioids, by physicians who are treating chronic intractable (non-malignant, benign) pain in some of Ohio's injured workers has been identified as a pattern as opposed to appropriate utilization.
- Appropriate use, careful surveillance and escalating vigilance with longer-term higher doses is required.

Statutes regarding the use of prescription medication for the treatment of intractable pain have changed considerably both nationally and in Ohio.

The State Medical Board of Ohio has established standards and procedures for physicians regarding the diagnosis and treatment of intractable pain. These rules are contained in Chapter 4731-21 of the Ohio Administrative Code.

The State Medical Board of Ohio Administrative Rule 4731-21-02 pertains to "utilizing prescription drugs for the treatment of intractable pain".

Since these rules provide the legal authorization and criteria for use of the prescription drugs for treatment of intractable pain, they must also be followed by physicians providing opinions for authorization of payment of such medications in claims in either file reviews or independent medical evaluations for BWC.

According to 4731-21-01 "Definitions" of The State Medical Board of Ohio Administrative Rules:

"Intractable pain" means a state of pain that is determined, after reasonable medical efforts have been made to relieve the pain or cure its cause, to have a cause for which no treatment or cure is possible or for which none has been found. "Intractable pain" does not include pain experienced by a patient with a terminal condition. "Intractable pain" does not include the treatment of pain

associated with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.”

To comply with this definition, reasonable medical efforts should have been made to relieve the pain or cure its cause and that the pain has a cause for which no treatment or cure is possible or at least none has been found. Therefore, intractable pain is considered only after reasonable medical efforts have been made to diagnose the cause of the pain and adequate and appropriate medical treatment has been provided to treat the cause. Many medical conditions seen in workers' compensation patients could be considered "intractable pain" such as, but not limited to, complex regional pain syndrome I or the chronic pain frequently associated with lumbar procedures such as postlaminectomy syndrome. Due to wide variance of symptoms and treatment over the clinical course of a condition, not all patients with these allowed conditions in the claim meet the definition of "intractable pain".

4731-21-02 provides the guidelines or expectations of physicians managing intractable pain with prescription drugs. Paragraph (A) requires:

- An initial evaluation that includes complete medical, pain, alcohol and substance abuse histories;
- Assessment of the impact of pain on physical and psychological functions;
- Review of previous diagnostic studies and previously utilized therapies;
- An assessment of coexisting illnesses, diseases or conditions; and
- An appropriate physical examination

The medical diagnosis must be documented that indicates the intractable pain along with the signs, symptoms, and causes of the pain. An individual treatment plan is required to be documented specifying the medical justification of the treatment of intractable pain with prescription drugs on a protracted basis, the intended role of prescription drug therapy within the overall plan, and other medically reasonable treatment for relief of the intractable pain that have been offered or attempted without adequate or reasonable success. The response to the treatment must be documented along with modifications to the treatment plan. Section (4)(a) of Paragraph (A) states that the diagnosis of intractable pain can be made only after having the patient "evaluated by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain." The prescribing physician is to maintain a copy of the report of the evaluation. The evaluation is not required if the patient has been evaluated and treated within a "reasonable period of time" by one or more other practitioners who specialize in the anatomic area, system, or organ perceived to be the source of pain and the treating practitioner is satisfied that he or she can rely on the evaluation to meet the requirements of the Rule. The practitioner is required to obtain and maintain a copy of the records or report on which he/she relied to meet the requirements of an evaluation by a specialist. Last, Paragraph (A) requires an informed consent be present retained in the medical record informing the patient of the risk and benefits of receiving prescription drug therapy and of available treatment alternatives.

Paragraph (B)(1) requires that the practitioner see the patients at "appropriate periodic intervals to assess the efficacy of treatment, assure that prescription drug therapy remains indicated, evaluate the patient's progress toward treatment objectives, and note any adverse drug effects". Paragraph (B)(2) also requires ongoing assessment of functional status, the pain intensity, and its interference with activities of daily living, quality of life, and social activities. If there is evidence or behavioral indications of drug abuse, the practitioner may obtain a drug screen. According to Paragraph (B)(3), "It is within the practitioner's discretion to decide the nature of the screen and which type of drug(s) to be screened." Results of the screening must be documented in the patient's medical record.

Paragraph (C) requires immediate consultation with an addiction medicine or substance abuse specialists if the practitioner believes or has reason to believe the patient is suffering from addiction or drug abuse.

Based on the above statutory and regulatory documents described, the use of prescription medication for the treatment of chronic intractable pain is acceptable in Ohio on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions so long as the treating physician complies with The State Medical Board of Ohio Administrative Rules. Based on Ohio Supreme Court decision, it is also required that the authorization of payment for services be reasonably related, reasonably necessary for treatment of the allowed injury, and that the costs are medically reasonable. To support the reasonably necessary

requirement, practitioners are expected to provide medical documentation to support intractable pain and the need to use prescription medication for the treatment of intractable pain when present. Medical records must also reflect or explain how the intractable pain and its treatment are reasonably related to the allowed injury in the claim.

Key elements expected to be present in the medical file include but are not limited to:

- Reasonable medical efforts (diagnostic study, consultation, and treatment) have been performed to relieve the pain, identify the source, and cure its cause.
- No other treatment or cure is possible or none has been found.
- The initial evaluation by the treating practitioner meets the requirements of Administrative Rule 4731-21-02. (Note: This is not intended to be point-by-point specific, but that the medical records do document sufficient history, pain description, relatedness of the pain to the allowed condition in the claim, alcohol and substance abuse history, assessment of physical and psychological function, diagnostic studies and treatment performed, and an appropriate physical examination.)
- Appropriate consultation has been performed either by consultation or previous treating specialist as defined by Administrative Rule 4731-21-02 within a reasonable period of time, not to exceed six (6) months from the beginning of such treatment.
- Medical records provide appropriate documentation to support continued use of the medication and consistent with Administrative Rule 4731-21-02. This includes adequate monitoring of the patient on a periodic basis to determine the continued need for prescription medication.

BWC expects practitioners to perform or receive authorization as part of the treatment guidelines for the following services:

- Periodic office visitation to monitor treatment compliance, results, physiologic and psychological functioning.
- In certain claims, it may be necessary to obtain periodic urine drug testing to determine drug abuse based on evidence or behavioral indications of addiction as described in OAC 4731-21-02 Paragraph (B)(3). This most likely would be no more frequent than quarterly.
- In all claims receiving medications for intractable pain, checking the OARRS report is advisable.
- Referral to an addiction medicine specialist or substance abuse specialist for consultation and evaluation (most likely each case would need to be evaluated for treatment) if the practitioner believes or has reason to believe the patient is suffering from addiction or drug abuse as described in 4731-21-02 Paragraph (C).

Since there is no specific allowance of “chronic intractable pain”, BWC personnel involved with claim management determinations and physicians performing file reviews or Independent Medical Evaluations for BWC should consider the following criteria in regard to the use of prescription medication to treat chronic intractable pain:

- That the medical records meet the definition of “intractable pain” as defined by the State Medical Board of Ohio particularly in relation to reasonable medical efforts to determine the source and treat the cause of the pain have been documented;
- That a second opinion from an appropriate specialist has been performed;
- That the medical records provide a reasonable relationship of the symptoms to the allowed conditions in the claim; and
- That the use of such medication is reasonably necessary to help manage the symptoms experienced by the injured worker.

If the above criteria are met, even though there is no allowance for chronic intractable pain on the claim, then the BWC may authorize reimbursement for prescription medication used in the treatment of chronic intractable pain.

In claim management, many, if not most, cases would be a continuation of or “flow-through” of treatment of a condition that is presumed to be the cause of pain and for which the injured worker has received appropriate diagnostic testing, treatment, and evaluations. Many individuals considered to have “chronic intractable pain”

will have obvious limitation of activity and difficulty controlling pain following treatment of the allowed condition. Other claims will be more difficult to assess. There may be issues of:

- Need for additional diagnostic testing;
- Need for specialist consultation;
- Uncertainty of diagnosis or relationship to the allowed conditions in the claim; or
- Medical records do not support the apparent need for continued treatment in which case, it can be anticipated that some employers may also request an independent medical evaluation of injured workers for the purpose of justification of ongoing treatment in many of these cases.

In questionable cases or those requested by the employer, an independent medical evaluation performed by a specialist is appropriate to determine issues such as:

- Recommendations for any additional testing to identify source of pain;
- Other treatment that should be considered;
- Specialty consultation that may be beneficial;
- Provide description of the pain and impact on daily living, functioning etc.;
- Clarify relationship of symptoms (pain) to the allowed conditions or work injury;
- Determine the apparent need for continued treatment; and
- Other issues as deemed necessary.

In most non- catastrophic workers' compensation cases, the presumed source of pain will be limited to the musculoskeletal system. Appropriate independent medical evaluating specialists will, in general, be limited to orthopedists, hand surgeons for the upper extremity, neurosurgeons, physical medicine and rehabilitation specialists, and possibly occupational medicine and pain specialists depending on the nature of the issue.

Treating physicians who consistently fail to provide appropriate medical records or follow The State Medical Board of Ohio rules will be referred to DEP Central or Provider Relations along with the specific claim numbers of injured workers being treated.

Note: For the complete BWC position paper including references, see <https://www.ohiobwc.com/provider/services/medpositionpapers.asp>

R. VERTEBRAL AXIAL DECOMPRESSION

BWC requires vertebral axial decompression (spinal decompression, decompression therapy) to be billed with the CPT code for mechanical traction and will pay one unit of service per visit, regardless of the length of time the traction is applied. The decision regarding authorization of decompression therapy will remain with the individual MCO.

Decompression therapy is intended to create negative pressure on the spine, so that the vertebrae are elongated, pressure is taken off the roots of the nerve, and a disk herniation may be pulled back into place. Decompression therapy is generally performed using a specially designed computerized mechanical table that separates in the middle.

The American Medical Association (AMA), FDA and Centers for Medicare and Medicaid Services (CMS) all consider decompression therapy to be a form of traction. The CPT© Assistant November 2004/ Volume 14, Issue 11 page 9 advises that the CPT code for manual traction, 97012, is the most appropriate code to report for various types of mechanical traction devices including vertebral axial decompression.

S. INTERFERENTIAL THERAPY

Interferential or sympathetic therapy is a type of electrical stimulation of the peripheral nerves that is designed to alleviate pain by inducing a systemic effect on sympathetically induced pain. Interferential stimulation is customarily provided on an outpatient basis for about twenty (20) treatment sessions followed by purchase of a home unit for the patient to self-administer the interferential therapy for an unlimited period of time. Following a review of the literature and coverage policies of other third party insurers, BWC has determined that

insufficient evidence exists to determine the effectiveness of “**self-administered**” sympathetic therapy/interferential therapy. BWC and the MCO will not reimburse the rental or purchase of a therapy unit used to self-administer interferential therapy. OAC 4123-6-07(C)

T. SMOKING DETERRENT PROGRAMS

BWC and the MCO responsible for medically managing a claim may consider reimbursement of an MCO approved/accredited smoking cessation program with or without FDA approved smoking deterrent drugs when specific guidelines are met. This positive behavioral modification program would include education and counseling regarding nicotine addiction and the use of nicotine replacement products, re-lapse prevention strategies, stress management techniques and/or other appropriate services that would treat an allowed pulmonary condition or improve the allowed pulmonary condition to enable the injured worker to return to work.

1. Reimbursement of smoking cessation programs.

BWC requires MCO approved/accredited smoking cessation programs to be billed with the following codes:

- **W5000** - Monitored smoking cessation program **with** FDA approved prescription smoking deterrent drugs. Services for smoking cessation with prescription drugs, when the allowed lung condition presents a barrier to meeting established treatment and return to work goals and when the Miller Criteria have been met.
- **W5001** - Monitored smoking cessation program **without** FDA approved prescription smoking deterrent drugs. Services for smoking cessation, without prescription drugs when the lung condition presents a barrier to meeting established treatment and return to work goals and when the Miller Criteria have been met.

2. Non-covered Services

BWC does not reimburse prescription smoking deterrent drugs outside an approved smoking cessation program. OAC 4123-6-07(D). Drugs are only reimbursed when included as part of a smoking cessation program. BWC’s pharmacy benefits manager (PBM) will not reimburse smoking deterrent drugs.

Note: Smoking deterrent drugs that are not FDA approved will not be reimbursed and shall not be billed to BWC or the MCO.

3. Provider Enrollment and Billing

Providers of smoking cessation programs are required to enroll as a BWC certified provider and bill for services on either the CMS-1500 or the BWC Service Invoice (C-19). Bills must then be submitted to the managing MCO for reimbursement.

U. ICD-CM ALLOWED “PAIN” CODES

Authorization, delivery, and payment of medical services and other benefits in the Ohio Workers’ Compensation System is dependent on a medical diagnosis (condition) being recognized as an “allowed” condition in a claim. Once a condition is recognized as “allowed”, BWC assigns the condition a code based on the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*.

In recent years the medical community has had increased focus on the treatment of pain and particularly chronic pain. In response, BWC recognizes several *ICD-9-CM* diagnostic codes to appropriately represent chronic pain as allowed conditions. These codes include the following which may be currently allowed in a claim:

- 719.4 pain in joint (fifth digit of code identifies specific body part)
- 307.89 other psychalgia or pain disorder associated with both psychological and general medical condition
- 337.21 Reflex Sympathetic Dystrophy (RSD), upper limb [Complex regional pain syndrome I of upper limb (CRPS I)]
- 337.22 Reflex Sympathetic Dystrophy (RSD), lower limb [Complex regional pain syndrome I of lower limb (CRPS I)]
- 337.29 Reflex Sympathetic Dystrophy (RSD) of other specified site
- 338.21 Chronic pain due to trauma

- 338.22 Chronic post-thoracotomy pain
- 338.28 Other chronic post-operative pain
- 338.29 Other chronic pain
- 338.3 Neoplasm related pain (acute)(chronic)
- 354.4 Causalgia of upper limb [Complex regional pain syndrome II of upper limb (CRPS II)]
- 355.71 Causalgia of lower limb limb [Complex regional pain syndrome II of lower limb (CRPS II)]
- 722.8 Postlaminectomy syndrome
- 724.6 Chronic lumbosacral sprain/strain (claim already allowed for lumbar/lumbosacral sprain/strain)
- 729.1 Fibromyalgia

Note: BWC Staff will indicate in the code descriptor the body part/region considered responsible/involved in the chronic pain.

Note: While BWC does not recognize “338.4 chronic pain syndrome” described as chronic pain associated with significant psychosocial dysfunction, any of the codes listed above may be additionally allowed for “307.89” or another psychiatric ICD-9 Code if the allowance criteria are met.

Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

ICD-9 Code: 307.89

Definition:

Chronic pain condition in which both psychological factors and a general medical condition are considered to be significant contributors to the disorder whether the psychological contribution contributes to the onset, severity, exacerbation, or maintenance of the pain. Evaluation and treatment in most cases will require evaluation and treatment of the medical conditions believed to be causing pain and evaluation and treatment of the psychological factors.

Note: This diagnosis is a secondary diagnosis or second diagnosis of an individual who is already recognized as having a chronic pain condition recognized by BWC. This condition may be combined with an allowance of a chronic pain disorder to provide the equivalent of chronic pain syndrome. In lieu of this diagnostic code, more specific psychiatric diagnostic codes (most commonly those of depression) may be appropriate and more specific.

Subjective:

- Symptoms of pain of whose onset, severity, or maintenance are believed to be significantly affected by psychological factors and a chronic medical pain condition.
- Individual must have a chronic pain allowance describing a general medical condition.

Objective:

- None specific.

Diagnostic Tests:

- Since this condition is considered a mental disorder, a psychological/psychiatric independent medical evaluation must be performed as in any other request for a psychological/psychiatric allowance.

Note: BWC does not recognize ICD-9 Code “307.80 Psychogenic pain, site unspecified” since this code is a primary mental health code and a medical condition has no or very minimal role.