

New/Revised/Updated Policies - Table of Contents

- ❖ NURSING HOME, RESIDENTIAL CARE AND ASSISTED LIVING FACILITY BILLING REQUIREMENTS..... BRM-01
- ❖ HEALTH AND BEHAVIOR ASSESSMENT AND INTERVENTION..... BRM-02
- ❖ ANESTHESIA BILLING AND REIMBURSEMENT..... BRM-03
- ❖ AMBULATORY SURGICAL CENTER BILLING AND REIMBURSEMENT..... BRM-04
- ❖ DRUG TESTING..... BRM-05
- ❖ CHRONIC PAIN MANAGEMENT PROGRAMS..... BRM-06
- ❖ OPIOID USE DISORDER TREATMENT COVERAGE..... BRM-07
- ❖ PAYMENT FOR LUMBAR FUSION SERVICES..... BRM-08
- ❖ TELEMEDICINE..... BRM-09
- ❖ OUTPATIENT MEDICATION PRIOR AUTHORIZATION PROGRAM..... BRM-10
- ❖ PROFESSIONAL PROVIDER GLOBAL SURGICAL PACKAGE..... BRM-11
- ❖ HOME HEALTH AGENCY SERVICES..... BRM-12
- ❖ CAREGIVER SERVICES..... BRM-13
- ❖ HOME AND VEHICLE MODIFICATIONS..... BRM-14
- ❖ INTERPRETER SERVICES..... BRM-15
- ❖ CATASTROPHIC CASE MANAGEMENT PLAN..... BRM-16
- ❖ EXPOSURE OR CONTACT WITH BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS WITH OR WITHOUT PHYSICAL INJURY..... BRM-17
- ❖ SPINAL DECOMPRESSION THERAPY..... BRM-18
- ❖ SMOKING DETERRENT PROGRAMS..... BRM-19
- ❖ TRAUMATIC BRAIN INJURY (TBI)..... BRM-20
- ❖ APPLICABILITY OF MEDICAL DOCUMENTATION SUBMITTED BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, and PHYSICIAN ASSISTANTS..... BRM-21
- ❖ DOCUMENTATION OF TIMED SERVICES..... BRM-22
- ❖ HOSPITAL SERVICES..... BRM-23
- ❖ TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS) & NEURO-MUSCULAR ELECTRICAL NERVE STIMULATORS (NMES)..... BRM-24

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BWC's Provider Billing and Reimbursement Manual

Policy Name:	Nursing Home, Residential Care and Assisted Living Facility Billing Requirements
Policy #:	BRM-01
Code/Rule Reference:	OAC 4123-6-08, 4123-6-02.2
Effective Date:	July 1, 2019
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding nursing home, residential care and assisted living that predate the effective date of this policy.
History:	REVISED 4/1/18
Review date:	07/01/2024

I. POLICY PURPOSE:

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the billing of nursing home, residential care and assisted living facility services to Ohio's injured workers.

II. APPLICABILITY

This policy applies to all parties involved in requesting, approving and reimbursing nursing home, residential care and assisted living facility services within the Ohio workers' compensation system.

III. DEFINITIONS

There are no definitions in this policy.

IV. POLICY

A. Nursing Home Services

1. Sub-acute facility and skilled nursing facility units within a hospital are enrolled separately as a Nursing Home.
2. Nursing home services included in the all-inclusive per diem rate:
 - a. Room and board;
 - b. Laundry services;
 - c. Activity programs;
 - d. Maintenance therapy;
 - e. Psychosocial services;
 - f. Non-prescription and prescription medications;
 - g. Personal hygiene supplies and services; and
 - h. Equipment not used solely for the use of the injured worker.
3. Billing and Reimbursement Requirements
 - a. The nursing home may bill separately for physical, occupational and speech therapy using CPT® codes.

- b. All bills, regardless of ownership, must be submitted to the MCO on the CMS-1500 using the appropriate all-inclusive per diem skilled nursing facility or intermediate level code.
- c. 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.
- d. Often, skilled nursing facility bills, especially when the skilled nursing facility is located in a hospital, are submitted as transfers from an inpatient stay to the skilled nursing facility. If the initial inpatient bill has already been paid, the skilled nursing facility's bill shall deny as a duplicate. The skilled nursing facility shall resubmit the charges on a CMS-1500 using the assigned provider number for the nursing home. If a hospital does not have a separate BWC provider number for its skilled nursing facility, it should contact BWC's provider enrollment department at 1-800-644-6292.
- e. Please refer to the [Professional Provider Fee Schedule](#) in effect on the date of service, for coding and reimbursement rates.
- f. Current fee schedules are published on BWC's website at <https://www.bwc.ohio.gov/provider/services/agreement.asp>.

B. Residential Care and Assisted Living Facilities

- 1. The facility must detail services provided and billed for in the all-inclusive per diem rate in the medical documentation.
- 2. Please refer to the [Professional Provider Fee Schedule](#) in effect on the date of service, for coding and reimbursement rates.
- 3. Current fee schedules are published on BWC website at <https://www.bwc.ohio.gov/provider/services/agreement.asp>.

Policy Name:	Health and Behavior Assessment and Intervention
Policy #:	BRM-02
Code/Rule Reference:	OAC 4123-6-32 , 4123-6-33 ; 4123-6-08 ; 4123-6-37.2 ; 4123-6-03.2 ; R.C. 4121.441; 4123.66
Effective Date:	07/01/2019
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding Health and Behavior Assessment & Intervention claims that predate the effective date of this policy.
History:	Revised 07/01/2019; New 04/01/2018
Review date:	04/01/2023

I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the appropriate identification, provision of, and billing of health and behavior assessment/intervention (HBAI) services available to eligible injured workers (IW) who may benefit from an assessment that focuses on identifying behavioral barriers impeding the injured workers' recovery which may be addressed through intervention services.

HBAI services are billed under code numbers 96150-96155, from the American Medical Association Common Procedural Terminology (CPT) manual. According to the CPT manual, these services focus "not on mental health but on biopsychosocial factors important to physical health problems and treatments." A physical diagnosis (not psychological diagnosis) is required as the diagnosis treated and billed for under the HBAI service codes. Those conditions treated by HBAI do not qualify as mental health conditions. HBAI is limited to coaching and counseling for behavioral barriers that are negatively impacting an IW's healing from a physical injury. These services are clearly distinguished in the CPT manual from psychological counseling (code numbers 90833-90838) and medical or chiropractic visits for physical conditions (code numbers 99211-99215). Use of HBAI services to diagnose or treat a psychological condition will not be reimbursed.

Although behavioral barriers may be present in mental health conditions, and mental health conditions may negatively impact physical recovery, they are two distinct and separate phenomena, and it is essential in HBAI to distinguish them. Emotional reactions are intrinsic to any injury, and in fact can be present in health or disease. These commonly include perceptions and expectations for recovery or disability, fear of re-injury, catastrophic thinking, and perceived injustice. The majority of injured workers recover fully without dedicated attention to these emotions. However, in some circumstances, they lead to behaviors which can negatively impact healing of

the physical injury, and so require additional coaching and counseling to achieve the goals of recovery.

Mental health conditions are distinctly diagnosed conditions, as individually defined in the International Classification of Diseases (ICD) manual, and often require medical management. Treatment of mental health conditions are not included in HBAI services and are treated under separate psychological counseling and medical treatment codes as indicated above.

II. APPLICABILITY

This policy is in direct support of [OAC 4123-6-33](#) and applies to all actions relevant to the request, approval and reimbursement of Health and Behavior Assessment and Intervention Services within the Ohio Workers' Compensation System.

III. DEFINITIONS

Health and Behavior Assessment: This is a procedure used to identify the behavioral, emotional, cognitive, and social factors important to the prevention, treatment, and/or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

Health and Behavior Intervention: These services are focused on improving the patient's health and well-being by utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems. These services do not represent preventive medicine counseling and risk factor reduction interventions. Services are limited to counseling and coaching.

Behavioral Barriers: Any identified factor that prevents the injured worker from adhering to treatment protocols or causes the injured worker to act in a manner which undermines the medical management and/or healing of an injured worker's allowed physical injuries, or that prevents the injured worker from effectively participating in the healing of the injured worker's allowed physical injury. Examples of these barriers may be negative perceptions and expectations for recovery or disability which cause the injured worker to withhold important feedback needed by the physician in determining necessary medical treatment, or fear of re-injury which leads to the injured worker not adhering to a prescribed therapeutic treatment regime.

Initial Course of Treatment: A generally accepted standard clinical approach to addressing a physical injury. The clinical approach may vary depending on the nature of the physical injury, and will generally result from the informed medical opinion gained from an examination and/or other appropriate clinical evaluations

Coaching: A service provided to the injured worker to help facilitate the injured worker's understanding of the impact of behavioral barriers and to establish action-oriented goals to help modify behavioral barriers to improve healing and function of the injured worker's allowed work injury.

Counseling: A service provided to the injured worker to facilitate the injured worker's understanding of the impact of behavioral barriers and to provide actionable guidance to help modify behavioral barriers to improve healing and function of the injured worker's allowed work injury.

IV. POLICY

A. IW Eligibility Criteria

An injured worker shall be eligible for consideration of health and behavior assessment/intervention services if:

- 1) The injured worker has the capacity to understand and respond meaningfully during the face-to-face encounter.
 - a) When requesting each HBAI service the physician of record (POR) must indicate that the injured worker meets this requirement.
 - b) An injured worker would not have the capacity to understand and respond meaningfully during the face to face encounter because of factors including but not limited to:
 - i) Dementia;
 - ii) Delirium;
 - iii) Severe and profound cognitive impairment;
 - iv) Persistent vegetative state or no discernible consciousness;
 - v) Impaired mental status; and
- 2) The injured worker meets the eligibility criteria in section IV.A.2) a) or IV.A.2) b) of this policy:
 - a) The injured worker's POR determines:
 - i) The injured worker is not progressing with their injury after the initial course of treatment, and
 - ii) The injured workers' healing appears to be delayed due to behavioral barriers; or
 - b) The injured worker is being evaluated by the POR, treating physician or operating surgeon for lumbar fusion surgery pursuant to rule 4123-6-32 of the Administrative Code.
- 3) References in this policy to "physician of record" shall also include the "treating physician or operating surgeon" with regard to HBAI services requested or performed in connection with lumbar fusion surgery pursuant to rule 4123-6-32 of the Administrative Code

B. Prior Authorization Request and Documentation for Health and Behavior Assessment or Re-assessment Services

- 1) Requests for health and behavior assessment or re-assessment services shall only be submitted by the POR on a Request for Medical Services Reimbursement or Recommendation of Additional Conditions for Industrial Injury or Occupational Disease (C-9) form or equivalent.
- 2) Requests for health and behavior assessment shall include:

- a) Documentation of the physical injury and treatment:
 - i) Onset and history of the initial diagnosis of the physical injury or occupational disease resulting in the allowed condition(s) in the claim;
 - ii) Summary overview of the IW's treatment and diagnostic studies to date, and applicable results;
 - b) A statement documenting the IW's ability to understand and respond meaningfully during the assessment;
 - c) The POR's clear rationale for the assessment, as demonstrated by:
 - i) Documentation of the behavior barriers that the POR believes exists; along with,
 - ii) A statement explaining how the injured worker's healing or recovery progress from the allowed condition(s) is impeded by the identified behavioral barriers;
 - d) A statement that the IW has not received a health behavior assessment in the prior twelve months.
- 3) Re-assessment may be considered reasonable and necessary when there has been a sufficient change in the injured workers' status warranting re-evaluation. The POR must provide clear rationale for why a re-assessment is required as demonstrated by information provided by the POR including:
- i) The date of the most recently performed health behavior assessment;
 - ii) The results of the prior health behavior assessment, including documentation of the behavioral barriers identified;
 - iii) Relevant reference to and outcomes of health behavior interventions received by the injured worker;
 - iv) New and changed circumstances in the IW's physical status requiring re-assessment.

C. Prior Authorization Request and Documentation for Health and Behavior Intervention Services

- 1) Requests for health and behavior intervention services shall only be submitted by the POR on a Request for Medical Services Reimbursement or Recommendation of Additional Conditions for Industrial Injury or Occupational Disease (C-9) form or equivalent.
 - 2) When a request for health and behavior intervention services is received the medical necessity and appropriateness of the request will be evaluated against the following information:
 - a) The most recent assessment report providing the basis for the request of intervention services;
 - b) Recommendation(s) for specific goals, frequency and duration of proposed intervention services;
 - c) Medical documentation which provides a clear rationale for the health behavior intervention, including an assessment of how the injured worker may benefit from the intervention.
 - d) Documentation of the IW's ability to understand and respond in a meaningful way to intervention services.
- 2) Limitation on providers of intervention services:

- a) Intervention services may not be provided by the same provider who performed the health and behavior assessment of the injured worker;
 - b) Intervention services can be provided by a provider who is a member of the same group practice of a provider who has performed the health and behavior assessment of the injured worker.
- 3) Prior to the POR's intervention services request being authorized, a completed health and behavior assessment report must be submitted and accessible to the MCO for a determination of medical necessity and appropriateness.
 - 4) Health and behavior intervention services are limited to coaching and counseling services that address behavioral barriers identified and/or validated in the assessment.
 - a) Intervention services can be provided by a provider who is a member of the same group practice of a provider who has performed the health and behavior assessment of the injured worker.
 - 3) Prior to the POR's intervention services request being authorized, a completed health and behavior assessment report must be submitted and accessible to the MCO for a determination of medical necessity and appropriateness.
 - 4) Health and behavior intervention services are limited to coaching and counseling services that address behavioral barriers identified and/or validated in the assessment.

D. Provider Eligibility

- 1) Health and behavior assessment, reassessment or intervention may be performed by any provider whose professional scope of practice as defined under state law includes health and behavior services, and includes the following providers:
 - a) Doctor of Osteopathic Medicine or Surgery (D.O.)
 - b) Doctor of Medicine (M.D.)
 - c) Doctor of Chiropractic (D.C.)
 - d) Certified Nurse Practitioner (CNP)
 - e) Clinical Nurse Specialist (CNS)
 - f) Certified Rehabilitation Counselor (CRC)
 - g) Occupational Therapist (OT)
 - h) Physician Assistant (PA)
 - i) Psychologist (Ph.D. or PsyD)
 - j) Licensed Social Worker or Licensed Independent Social Worker
 - k) Licensed Professional Counselor or Licensed Professional Clinical Counselor
- 2) BWC will recognize any provider type not listed in Section D 1) as eligible to provide health and behavior services upon submission of documentation satisfactory to BWC from their state's licensing board that the service is within their defined scope of practice.

E. Provider Documentation after rendering an Assessment, Re-assessment, or Intervention

- 1) For any provider completing a health behavior assessment or re-assessment, a report of findings must be submitted to the POR and MCO, that shall include at a minimum the following information, as appropriate:
 - a) History of the industrial injury or occupational disease resulting in the allowed condition(s) in the claim, including the date of the physical injury;
 - b) Overview of the IW's treatment and diagnostic studies to date, and the results;
 - c) Identification and/or validation of existence of behavioral barriers or documentation to negate the existence of behavioral barriers;
 - d) A statement signifying whether the IW's healing or recovery progress from the allowed condition(s) is or continues to be impeded by the identified behavioral barriers;
 - e) Recommendation(s) for specific goals and duration or recommended changes to goals and durations of proposed intervention services;
 - f) The results of one or more currently accepted health-focused questionnaire or risk screening tools. Those tools may include but are not limited to:
 - i) Keele STarT Back Screening Tool (SBST);
 - ii) Screener and Opioid Assessment for Patients with Pain (SOAPP);
 - iii) World Health Organization Disability Assessment Schedule 2.0 (WHODAS);
 - iv) Fear Avoidance Belief Questionnaire (FABQ);
 - v) Linton Tool;
 - vi) Functional Recovery Questionnaire (FRQ).
 - g) Length of time of assessment, including start and stop time.
- 2) To assist in the determination of appropriateness of reimbursement for intervention services performed, providers of intervention services must submit medical documentation which includes, at a minimum:
 - a) An overview of the intervention performed, including a reflection of the goals of the intervention services;
 - b) Documentation of the IW's progress or lack of progress towards the goals of the intervention services for each visit;
 - c) Description of the IW's engagement in his or her treatment; and
 - d) The time in and time out and duration of health and behavior intervention services.

F. Not Covered Intervention Services:

- 1) Preventive medicine counseling and risk factor reduction interventions are determined to not be reasonably related to, or medically necessary for, treatment of an industrial injury, and therefore are not reimbursable.
- 2) Because the focus and goals of Health and Behavior Intervention Services are directed to treating an injured worker's physical injury, coaching and counseling services focused on personal, social, recreational, and general support are not reimbursable Health and Behavior Intervention Services. Examples are:
 - a) Family psychotherapy or mediation;
 - b) Personal, social, recreational, and general support services;

- c) Maintain the patients or family's existing health and overall well-being;
- d) Individual social activities;
- e) Teaching social interaction skills;
- f) Socialization in a group setting;
- g) General conversation;
- h) Vocational or religious advice;
- i) Tobacco or caffeine withdrawal support;
- j) Teaching the patient simple self-care;
- k) Exercise programs;
- l) Weight loss management;
- m) Maintenance of behavioral logs;
- n) Updating or educating family about the injured worker's condition;
- o) Educating non-immediate family members, non-primary care-givers, non-guardians, the non-health care proxy, and other members of the treatment team, e.g., health aides, nurses, physical or occupational therapists, home health aides, personal care attendants and co-workers about the injured worker's care plan;
- p) Treatment planning with staff;
- q) Education of diabetic patients and their family members;
- r) Medical nutrition therapy;
- s) Maintaining the injured worker's or family's existing health and overall well-being;
- t) Provision of support services, not requiring the skills of a mental health provider;
- u) Provision of personal, social, recreational, and general support services;
- v) Stress management;
- w) Craft skill training;
- x) Cooking classes;
- y) Comfort care services;
- z) Social activities;
- aa) Consciousness raising;
- bb) General educational activities;
- cc) Sensory stimulation;
- dd) Games;
- ee) Grooming skills or services;
- ff) Monitoring activities of daily living;
- gg) Teaching self-care;
- hh) Memory enhancement training;
- ii) Case management;
- jj) Activity principally for diversion.

G. Billing and Reimbursement

- 1) The following providers must use the appropriate Evaluation and Management (E&M) CPT® codes (99201-99205 and 99211-99215) for reimbursement for health and behavior assessment and intervention services:

- a) Doctor of Medicine,
 - b) Doctor of Osteopathic Medicine or Surgery,
 - c) Doctor of Chiropractic,
 - d) Certified Nurse Practitioner,
 - e) Clinical Nurse Specialist,
 - f) Physician Assistants.
- 2) The following providers must use health and behavior CPT® codes (96150-96160) for reimbursement for health and behavior assessment and intervention services:
- a) Psychologist,
 - b) Licensed Social Worker,
 - c) Licensed Independent Social Worker,
 - d) Licensed Professional Counselor,
 - e) Licensed Professional Clinical Counselor,
 - f) Clinical Rehabilitation Counselor,
 - g) Occupational Therapist.
- 3) Reimbursement shall be made only when the health and behavior CPT® code is billed with a diagnosis for the physical injury allowed in the claim.
- 4) Reimbursement is subject to the following frequency limitations, except as otherwise provided pursuant to OAC 4123-6-32, *Payment for Lumbar Fusion*:
- a) One health behavior assessment per twelve-month period;
 - b) One reassessment per twelve-month period may be approved for an injured worker, to evaluate progress after receiving health behavior intervention services;
 - c) Six hours of health behavior intervention services every twelve months. Additional intervention services may be approved during the year, if the POR provides documentation that the additional services are medically necessary.
 - d) The twelve-month period is a look-back for twelve months from the date of the prior authorization C-9 request for the health and behavior assessment, reassessment or intervention services.

H. Addendum: HBAI Clinical Examples

- 1) Consider the situation in which an injured worker (IW) returns to her physician of record (POR) for reevaluation of her knee injury at an interval at which the provider would have expected full recovery. At the time of the visit, the knee looks red, feels warm, and is swollen. Because of these physical signs, the POR would order medically necessary and appropriate diagnostic studies to direct further treatment for the knee. Consider an alternative scenario where the IW arrives back for follow up with the knee looking as though it is healing properly, however is stiff with decreased range of motion, and is causing the IW to walk with a lurch. There is poor eye contact, a request for more pain medicine, a history of some missed therapy visits, and reports from the family that the IW is not walking as much as was prescribed "because she is afraid she'll hurt it again." It is in this second scenario that the POR should be concerned that these signs point to behavioral barriers to the IW's physical

recovery, specifically activity avoidance due to fear of re-injury. In this situation, referral for HBAI assessment is appropriate to address the behavioral barriers to physical healing, especially considering the alternatives of further unnecessary testing, possibly unnecessary procedures, more ineffective physical therapy in which the patient is not engaged, or perpetuation and/or escalation of opioid pain medication.

- 2) An IW is under the care of an ophthalmologist for treatment of a corneal (eye) abrasion. An ointment is prescribed. The IW returns to the provider after one week with red, irritated eyes. After additional questioning, the provider discovers that the ointment is causing burning and itching, and the IW has been rubbing his eyes. The provider gives coaching and counseling for the IW to avoid the behavior of eye rubbing, as part of the normal course of the visit.
- 3) An injured worker was giving a presentation to her team and a group of prospective clients. As she pulled down the projection screen, it came loose from the wall striking her on the head and knocking her to the floor. She was diagnosed with contusion to the head and left hip, and cervical strain. She was prescribed chiropractic care and physical therapy. She complained of continued neck pain and headache after an initial course of treatment. Tight muscles and decreased range of motion was observed by her POR, however she also confided that she was very embarrassed by the incident and felt ashamed to go back and face her coworkers and clients, afraid they would think she was clumsy and inept. Her physical therapist noted that she did not appear fully engaged in her exercise program. Because of these behaviors, her POR requested HBAI, with intervention focused on cognitive and behavioral retraining.
- 4) An IW presents to the office complaining of moderate to severe low back pain after lifting a 50-pound drum off a skid at work. He describes the pain as a sharp, stabbing sensation bilaterally across his low back. He was seen at the ER where he was instructed to use ice and pain medication and stay off for three days. He was instructed that if the pain persisted after three days that he was to consult his family physician or follow-up at the hospital's Occupational Medicine department. At the follow up appointment, he had decreased range of motion and tests reproducing the pain along the lumbar spine. He was diagnosed with Acute Lumbar Sprain. The IW stated that he had trouble with his daily activities, especially walking short distances, getting up and down out of a seated position, and disturbed sleep. Simple household tasks such as light cleaning and doing the dishes were difficult to perform or complete since the injury. He stated he has never had anything like this before and feels helpless since getting hurt at work. He stated that he wants to get back to work, but not too soon in case he would re-injure his back and make things worse. Physical therapy and medication were prescribed, as well as a walking program. At follow up, evaluation for return to work was planned. However, this initial course of conservative medical care produced minimal improvement in pain control or function. Below are details of the initial care, and then some medical decision-making options:

BWC's Provider Billing and Reimbursement Manual

Scenario #1	Scenario #2
3x/week for 4 weeks PT – Est. Cost: \$1200.00 L/S X-ray – Est. Cost: \$65.26	3x/week for 4 weeks PT – Est. Cost: \$1200.00 L/S X-ray – Est. Cost: \$65.26
One-month supply of Pain Meds: Est. \$800.00	One-month supply of Pain Meds– Est. \$800.00
Established Patient Exam (Re-eval): Est. \$100.00	Established Patient Exam (Re-eval): Est. \$100.00
At 4 weeks, POR could: <ol style="list-style-type: none"> 1. Extend PT additional time 2. POR could increase pain meds 3. Request additional diagnostic testing 4. Request consultation with a specialist 	At 4 weeks, POR could: <ol style="list-style-type: none"> 1. Extend PT additional time 2. POR could increase pain meds 3. Request additional diagnostic testing 4. Request consultation with a specialist
Decision Time- Minimal Improvement @ 4wks IW reports high pain levels and says he cannot perform ADL's Objective signs noted by POR indicate better than reported results by IW; however, POR determines to take a different approach with this case given the history, subjective, and objective findings IW has missed a few PT appointments because he feared re-injury and it hurt worse at times	Decision Time-Minimal Improvement @ 4 wks. IW reports high pain levels and he cannot perform ADL's IW has missed a few PT appointments because he feared re-injury and it hurt worse at times Objective signs noted by POR indicate better than reported results by IW, but determines to move forward with generally accepted medical approaches
Behavioral Barriers identified: <ul style="list-style-type: none"> • Feeling of helplessness as noted by IW • Missed a few PT appts. • Not stretching at home • Fear of re-injury Can't perform ADL's – too much pain	
HBAI OPTION: HBA requested – Est. Cost: \$122.36 Identified Coping and/or Behavior Barriers – Intervention Services requested – Est. Cost: \$449.44 HBA Reassessment at 6 weeks: \$87.33	CONTINUED MEDICAL CARE: Order MRI: Est. cost: \$298.77 Additional PT 2-3x/wk for 4 weeks – Est. cost \$1000.00 Additional supply of Pain Meds - \$Est. 800.00
POR develops strategy after barriers have been identified, confirmed, and addressed (i.e. helping him cope with his “fear of re-injury”) – IW returns to work light duty for two weeks with recommended PT 1xwk for 6 weeks (Est. cost- \$600.00) as transition back to work – IW back to work FD at 4 weeks from transition of LD – IW continues to utilize home exercise and coping skills strategy – Pain medications are discontinued and IW is back to work.	IW reports no better POR recommends Pain Management Specialist Consult –Est. cost \$200.00 Pain specialist recommends Injections – Est. cost \$800.00 for (2) – Total: \$1000.00 <i>IW still not back to work. Spine surgery consultation requested.</i>
Estimate in Total Care Costs \$3424.39 (savings in TT not included)	Estimate in Total Care Costs \$5464.03 <i>Still not back to work</i>

BWC's Provider Billing and Reimbursement Manual

Policy Name:	Anesthesia Billing and Reimbursement
Policy #:	BRM-03
Code/Rule Reference:	OAC 4123-6-08
Effective Date:	April 1, 2018
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding anesthesia services that predate the effective date of this policy.
History:	REVISED
Review date:	04/01/2023

I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the billing of anesthesia services to Ohio's injured workers.

II. APPLICABILITY

This policy applies to all actions relevant to the reimbursement of anesthesia services within the Ohio workers' compensation system.

III. DEFINITIONS

There are no definitions in this policy.

IV. POLICY

- A. BWC requires that providers bill anesthesia CPT® codes 00100 - 01999.
- B. Refer to the [Professional Provider Fee Schedule for coding and reimbursement in effect on the date of service](#). The anesthesia base unit list and fee schedule is located at <http://www.bwc.ohio.gov/provider/services/agreement.asp>.
- C. If there are multiple procedures performed, the provider must bill only the anesthesia CPT® code of the primary procedure.

The provider may not bill CPT® codes for services other than general anesthesia with general anesthesia modifiers. BWC shall deny bills with explanation of benefits (EOB).

- D. 380 EOB code: Payment is denied as the anesthesia modifier is not appropriate to be billed with this procedure code.

BWC's Provider Billing and Reimbursement Manual

- E. Although BWC accepts industry standard modifiers for anesthesia services, the provider may not use modifiers -P1 through -P6 for physical status.
- F. 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. Providers may not bill for these services separately.
- G. Evaluation and management codes billed within the surgical follow-up period are not reimbursable.
- H. Anesthesia time:
 - 1. Anesthesia time begins when the anesthesiologist or anesthesiologist is in personal attendance at the surgical procedure and ends when the anesthesiologist or anesthesiologist is no longer in personal attendance.
 - 2. BWC measures anesthesia time in minutes.
 - 3. Providers shall bill the minutes involved delivering anesthesia during the surgical procedure and shall not include the base units.

BWC's Provider Billing and Reimbursement Manual

Policy Name:	Ambulatory Surgical Center Billing and Reimbursement
Policy #:	BRM-04
Code/Rule Reference:	OAC 4123-6-37.3
Effective Date:	April 1, 2018
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding ambulatory surgical center services that predates the effective date of this policy.
History:	REVISED
Review date:	04/01/2023

I. POLICY PURPOSE:

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the billing of ambulatory surgical center (ASC) services to Ohio's injured workers.

II. APPLICABILITY

This policy applies to all actions relevant to the reimbursement of ASC services within the Ohio Workers' Compensation System.

III. DEFINITIONS

There are no definitions for this policy.

IV. POLICY

A. Covered Services/Reimbursement

1. BWC reimburses ASCs using a fee schedule based on Medicare's ambulatory surgical center prospective reimbursement system. The modifications adopted by BWC are specified in Ohio Administrative Code ([OAC](#)) [4123-6-37.3](#).
2. Providers shall refer to the [ASC Fee Schedule](#) effective on the date of service for additional information.

B. Bundled Services:

1. The following services are bundled into the reimbursement for surgical procedures and are not separately reimbursable:
 - a. Nursing, technician and related services;
 - b. Use of the facility where the procedure is performed;
 - c. Drugs, biologicals (e.g., blood), surgical dressings, splints, casts, appliances and equipment directly related to the provision of the surgical procedures for which separate payment is not allowed;

BWC's Provider Billing and Reimbursement Manual

- d. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
 - e. Administrative or record keeping items and services; and
 - f. Materials used for anesthesia.
2. Bundled services are identified by coverage status **BN** in the ASC fee schedule appendix tables.
- C. Non-Covered Services. The following services are not reimbursable if billed by an ASC, but may be billed separately by a BWC enrolled provider that is licensed to provide the services:
1. Physician services;
 2. Prosthetic and orthotic devices; and
 3. Durable medical equipment for use in the injured worker's home.
- D. Modifiers
1. BWC accepts nationally recognized Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) modifiers for ambulatory surgical center services in effect on the billed date of service, except for bilateral procedures.
 - a. BWC does not follow Medicare standard billing protocols for billing of bilateral procedures by an ASC.
 - b. Reporting of bilateral procedures should be billed with modifier -50, and not with -RT or -LT.
 2. Modifier reimbursement impacts are identified in the ASC fee schedule [OAC 4123-6-37.3](#) effective on the date of service.
 3. Modifier Reporting Examples:
 - a. Bilateral services with modifier -50: Bilateral lumbar transforaminal epidural injections are administered. The correct way to bill this bilateral procedure is CPT code® 64483-50. Do not bill 64483 and 64483-LT or 64483-RT and 64483-LT.
 - b. Multi-level Spinal Procedures - Below are two (2) examples of the correct reporting for multi-level spinal procedures.
 - i. Example - Lumbar transforaminal epidural injections are administered at L1, L2 and L3. The correct way to bill these procedures is CPT code® 64483, 64484-59 and 64484-59. Do not use modifiers L1, L2 or L3.
 - ii. 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, 64484-50,-59 and 64484-50,-59. Do not use modifiers L1, L2, or L3.
 - c. Multiple Tendons, Ligaments, Muscles or Joints - Below are two (2) 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.
 - i. Example - Excision of four (4) 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, 26180 -F6, 26180 -F7, and 26180 -F8. Do not use modifiers J1-J4.
 - ii. Example - Excision of four (4) 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, 26180 -F5 -59, 26180 -F6, and 26180 -F6 -59. Do not use modifiers J1-J4.

Policy and Procedure Name:	Drug Testing
Policy #:	BRM-05
Code/Rule Reference:	R.C. 4121.441, 4123.66; OAC 4123-6-08, 4123-6-16.2, 4123-6-25
Effective Date:	09/23/16
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding urine drug testing that predate the effective date of this policy.
History:	Rev. 08/11/15, 12/11/13, 05/09/14 Republished 04/01/18
Review date:	09/23/21

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the utilization of drug testing (DT) for injured workers (IW), especially those who are receiving or being considered for chronic opioid therapy in the management of chronic non-cancer pain.

II. APPLICABILITY

This policy applies to MCOs and providers of drug tests.

III. DEFINITIONS

Alternative drug testing (ADT): a chemical analysis of bodily specimens, with the exception of urine, that are obtained to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

Chronic opioid therapy: the consistent use of opioids for more than ninety (90) days.

Chronic pain: discomfort (i.e., pain) that extends beyond the expected period of healing.

Point-of-care testing: done at or near the site of patient care using commercial devices (e.g., in-office urine drug testing).

Urine drug testing (UDT): a chemical analysis of the urine to identify presence or absence of parent drugs or their metabolites. For the purpose of this policy, it is inclusive of both the immunoassay and a confirmation test such as gas chromatography, mass spectrometry or high-performance liquid chromatography.

IV. POLICY

BWC's Provider Billing and Reimbursement Manual

- A. It is the policy of BWC to:
1. Ensure appropriate use of opioids in the treatment of chronic pain management by allowing DTs;
 2. Require provider submission of the IW's level of risk to the MCO prior to determining the appropriate number of DTs to authorize for the IW;
 3. Allow up to four DTs yearly as determined by the injured worker's (IW) individual risk assessment, which shall be submitted no less than once a year; and
 4. Allow up to two additional DTs yearly when a provider documents the demonstration of aberrant behavior by an IW.
- B. Drug testing methods:
1. It is the policy of BWC that UDTs are the preferred method of drug testing.
 2. It is the policy of BWC to allow Alternative Drug Testing (ADT) (e.g., blood, saliva and hair follicle):
 - a. **Only** when a urine specimen is unobtainable due to medically documented reasons; and
 - b. **Only** when testing facilities/labs use FDA approved test kits/devices to obtain ADTs.
- C. It is the policy of BWC to reimburse for:
1. DT performed in a laboratory that is CLIA (Clinical Laboratory Improvement Amendments) certified;
 2. DTs performed following the process outlined in the procedure section of this document;
 3. DT billed under codes reflected in this link ([DT codes](#)).
 4. Quantitative testing for an individual drug that the IW is prescribed which is not included in the standard drug panel listed in C.5;
 5. A standard drug panel immunoassay test that includes the following drugs:
 - a. Amphetamines;
 - b. Opiates;
 - c. Cocaine;
 - d. Benzodiazepines;
 - e. Barbiturates;
 - f. Oxycodone;
 - g. Methadone;
 - h. Fentanyl;
 - i. Marijuana; and
 - j. Hydrocodone.
 6. DT that includes the standard drug panel listed above in Section IV.C.5. a-j, when the IW is taking a prescription drug that is not paid for by BWC.
 7. Additional tests for drugs not included in the standard drug panel listed above in Section IV.C.5. a-j when:
 - a. The IW is prescribed the drug; and/or
 - b. The physician deems the testing medically necessary.
 8. Point-of-care DTs when medical documentation identifies an immediate need.
 9. Drug confirmation by gas chromatography, mass spectrometry or high-performance liquid chromatography solely for the drug in question when the immunoassay results are positive or when:
 - a. An unexpected drug or its metabolites are identified;
 - b. The prescribed drug or its metabolites are not identified in the DT.

10. DTs 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).
11. DTs while a patient is on opioid therapy for chronic non-cancer pain to:
 - a. Verify compliance with the treatment regimen; and/or
 - b. Identify undisclosed drug use and/or abuse.

V. PROCEDURE FOR UDT AND ADT COLLECTION

A. UDT

1. Providers of urine drug tests shall ensure a collection protocol that protects the security and integrity of the urine collection by:
 - a. Testing the IW as soon as possible after the physician order is given;
 - b. Verifying the IW's identification via a photo identification or other confirming ID;
 - c. Collecting only one specimen at a time;
 - d. Having the IW remove any garments which might conceal substances or items to adulterate the urine specimen;
 - e. Instructing the IW to wash and dry his/her hands prior to urination;
 - f. Securing all water sources;
 - g. Ensuring the water in the toilet tank and bowl are blue;
 - h. Inspecting the testing site to ensure no unauthorized substances are present;
 - i. Removing all soaps, disinfectants, cleaning agents or other possible adulterants from the testing area;
 - j. Providing individual privacy for the IW during specimen collection;
 - k. Measuring the specimen temperature within four (4) minutes of its collection to ensure the temperature is between 90-100 Fahrenheit;
 - l. Visually inspecting the urine for color and contaminants;
 - m. Sealing and labeling the specimen with seals containing the date and specimen number in the presence of the IW;
 - n. Having the IW initial the seals, certifying that it is his/her specimen.
 2. A chain of custody form (appendix A) or equivalent form containing a minimum of the following elements shall be used in the collection and processing of the urine specimen:
 - a. IW's name, address, date of birth, signature, date of signature and claim number;
 - b. Collection site's name, address, phone and fax number;
 - c. Reason for the test;
 - d. Drugs to test for;
 - e. Specimen temperature within four (4) minutes of collection;
 - f. Additional comments;
 - g. Collection time, date and printed name and signature of collector;
 - h. Date and name of courier to whom the specimen was released;
 - i. Printed name and signature of lab employee receiving the specimen and the date of specimen receipt;
 - j. Documentation that the specimen bottle seals were intact upon the labs receipt of the specimen;
 - k. Results and result date.
- B. ADT shall be collected pursuant to the FDA approved drug kit.
- C. Specimens failing to meet the above listed criteria shall be rejected for testing.

BWC's Provider Billing and Reimbursement Manual

Chain of Custody Form Appendix A

Injured worker (donor) demographics		
Name:	Contact number:	Claim number:
Address, City, State and Zip Code:		Date of birth:
I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.		
Injured worker's signature:		Date (mm/dd/yy):
Collection site demographics		
Name:		Address, City, State and Zip Code:
Phone number:	Fax number:	
To be completed by the collector		
Reason for testing: <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/cause <input type="checkbox"/> Follow-up <input type="checkbox"/> Other (specify) _____		
Drug test to be performed: <input type="checkbox"/> Amphetamines <input type="checkbox"/> Opiates <input type="checkbox"/> Cocaine <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Oxycodone <input type="checkbox"/> Methadone <input type="checkbox"/> Fentanyl <input type="checkbox"/> Marijuana metabolite <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Other (specify) _____		
Temperature within 90 and 100 F within 4 minutes of collection: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Specimen collection: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None provided (explain) _____		
Additional observations:		
Time of collection:	Date of collection (mm/dd/yy):	
<i>I certify that the specimen given to me by the donor was collected, labeled, sealed and released to the courier service noted in accordance with applicable Federal requirements.</i>		
Collector's name (please print):	Signature of collector:	
Time of specimen release:	Date of specimen release (mm/dd/yy):	
Name of courier the specimen bottles were released to: _____		
To be completed by the lab upon receipt of the specimen		
Accessioner's name (please print):	Signature of accessioner:	
Specimen receipt date:	Specimen bottle seal intact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of person specimen bottles released to: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Dilute <input type="checkbox"/> Test cancelled <input type="checkbox"/> Refusal to test <input type="checkbox"/> Adulterated <input type="checkbox"/> Substituted Remarks: _____		
Positive for: <input type="checkbox"/> Amphetamines <input type="checkbox"/> Opiates <input type="checkbox"/> Cocaine <input type="checkbox"/> Benzodiazepines <input type="checkbox"/> Barbiturates <input type="checkbox"/> Oxycodone <input type="checkbox"/> Methadone <input type="checkbox"/> Fentanyl <input type="checkbox"/> Marijuana metabolite <input type="checkbox"/> Hydrocodone Other (list): _____		
Remarks:		
Lab technician's name (please print):	Signature of Lab technician:	Date (mm/dd/yy):

Policy Name:	Chronic Pain Management Programs
Policy #:	BRM-06
Code/Rule Reference:	OAC 4123-6-02.2(C)(13) , OAC 4123-6-08 , OAC 4123-6-10 OAC 4123-6-37.2 , OAC 4123-6-40
Effective Date:	07/01/2018
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding chronic pain management programs that predate the effective date of this policy.
History:	Revised
Review date:	07/01/2023

I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the billing of chronic pain management programs for Ohio's injured workers.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of chronic pain management programs within the Ohio workers' compensation system.

III. DEFINITIONS

There are no definitions for this policy.

IV. POLICY

A. Chronic Pain Management Program Requirements

Chronic pain management programs must include a multidisciplinary, comprehensive treatment approach that addresses the physiological, psychological, social and vocational aspects of chronic pain.

1. Chronic pain management program objectives shall include but are not limited to:
 - a. Maximize physical function (strength, stamina and flexibility) within the constraints of the injured worker's physical limitations;
 - b. Reduce or eliminate overuse of health services and invasive medical procedures relative to the primary pain complaints;
 - c. Reduce or eliminate the use of pain medications;
 - d. Reduce the subjective pain intensity by relieving pain and/or modifying the injured worker's reaction to the pain;
 - e. Develop skills for self-management of chronic pain and related problems;
 - f. Improve emotional function and reduce harmful emotional states associated with chronic pain;
 - g. Improve interpersonal relationships;

- h. Identify vocational goals, if applicable;
- i. Return to work-readiness, if applicable.
- 2. Program services may include but are not limited to:
 - a. Physician services;
 - b. Psychological services (individual and/or group);
 - c. Physical therapy;
 - d. Occupational therapy;
 - e. Group educational services;
 - f. Acupuncture;
 - g. Biofeedback;
 - h. Chiropractic treatment;
 - i. Diagnostic testing;
 - j. Laboratory testing, including drug testing;
 - k. Nutritional counseling;
 - l. Recreational therapy; and
 - m. Structured progressive withdrawal from pain medications.

B. Chronic Pain Management Program Types

- 1. Services may be provided by hospital or free-standing chronic pain program provider types.
- 2. Inpatient Programs (hospital provider types only)
 - a. Inpatient programs are appropriate only when injured worker's condition is such that a highly supervised and monitored program is essential for success. Inpatient programs are appropriate when one (1) or more of the following conditions are met:
 - i. The injured worker requires structured, progressive reduction of a prescribed medication before any possible benefit of the pain management program can be realized;
 - ii. The injured worker exhibits personality/behaviors such that effective participation would be unlikely in an unsupervised/unmonitored setting;
 - iii. The injured worker requires a structured environment for psychological support and/or medical monitoring;
 - iv. The injured worker's pain behavior is reinforced in the home to the point that it is necessary for the injured worker to be removed from the home in order to succeed in a chronic pain management program.
 - v. The injured worker will not be granted frequent off-site passes.
 - b. An inpatient program of three (3) to four (4) weeks is generally appropriate to modify pain behavior. On occasion, a program longer than four (4) weeks may be appropriate when substantiated by medical documentation.
- 3. Outpatient Programs (hospital provider types or free-standing chronic pain programs)
 - a. Outpatient programs are appropriate when the injured worker's condition does not warrant the highly supervised environment of an inpatient program.
 - b. Half day programs are required to include a minimum of three and one half (3 1/2) hours of treatment, excluding break and meal times.
 - c. Full day programs are required to include a minimum of seven (7) hours of treatment, excluding break and meal times.
 - d. Treatment times (i.e. start and end time or service duration) for each service shall be documented in the injured worker's medical record to ensure compliance with the full or half day treatment requirements.

C. Injured Worker Eligibility Requirements

1. In order to be eligible for participation in a chronic pain management program, the injured worker must meet the following requirements:
 - a. The injured worker is symptomatic of excessive pain behaviors disproportionate to the compensable injury or condition;
 - b. The injured worker has not responded to traditional medical treatment;
 - c. The cause of the injured worker's pain is unknown or attributable to a physical cause (i.e. not purely psychogenic in origin);
 - d. The injured worker's pain has affected his/her level of function for activities of daily living;
 - e. The injured worker's current use/abuse of alcohol or drugs is not expected to interfere with full participation in the program;
 - f. The injured worker is not currently experiencing any acute medical problems, is not anticipating any medical or surgical intervention and is considered to be medically stable to participate in a multidisciplinary, physically challenging program;
 - g. The injured worker has previously completed no more than one (1) multidisciplinary pain management program;
 - h. The injured worker is demonstrating significant emotional distress (e.g. Depression, anxiety or impaired interpersonal, familial, occupational or social functioning)
 - i. As a result of pain associated with the allowed injury; and
 - ii. The injured worker is psychiatrically stable, such that they can actively and safely participate in the program.
 - i. The injured worker has expressed interest and desire to participate in a chronic pain management program with a goal of returning to work, if appropriate;
 - j. The injured worker has the cognitive ability to understand and carry out instructions.
2. The injured worker is not required to have a psychological allowance in his/her claim to be eligible for participation a chronic pain management program

D. Injured Worker Eligibility Evaluation

1. When a physician of record (POR) or treating physician determines an injured worker may benefit from a chronic pain management program, the physician shall request prior authorization for a comprehensive, multidisciplinary chronic pain management program eligibility evaluation (i.e. pre-admission evaluation).
2. The evaluation shall be performed on an outpatient basis at the hospital or free-standing chronic pain management program facility.
3. The injured worker program eligibility evaluation shall include:
 - a. Medical history and physical/neuromuscular examination which includes review of medications;
 - b. Review of past, pertinent medical records;
 - c. Psychological and social evaluation;
 - d. Physical therapy evaluation;
 - e. Occupational therapy evaluation;
 - f. Cardiac stress test, if necessary; and
 - g. Specialist consultation(s), if necessary

4. Documentation from the injured worker eligibility evaluation shall be submitted to the MCO and shall include:
 - a. Indication if the injured worker meets each of the eligibility criteria listed in section IV.C.1. of this policy;
 - b. Identification of barriers, if any, preventing the injured worker from participating in the program;
 - c. Preliminary recommended treatment plan, if injured worker meets eligibility requirements and no other barriers exist.

E. Chronic Pain Management Program Authorization

1. Following the injured worker eligibility evaluation, the POR or treating physician shall request prior authorization for the chronic pain management program. The request shall include:
 - a. Program type (inpatient or outpatient);
 - b. Frequency and duration of treatment (e.g. full day or half day request for outpatient services).

F. Billing and Reimbursement

1. Injured worker eligibility evaluation
 - a. Services provided under section IV.D. of this policy shall be reported using BWC local level code for chronic pain program preadmission evaluation, per day, as listed in the hospital outpatient reimbursement rule ([OAC 4123-6-37.2](#)) and in the professional provider and medical services reimbursement rule ([OAC 4123-6-08](#)).
 - b. Hospitals shall submit bills for the injured worker eligibility evaluation on the CMS-1450 (UB-04 Uniform Bill form).
 - c. Free-standing chronic pain programs shall submit bills for the injured worker eligibility evaluation on the CMS-1500 (Health Insurance Claim Form).
 - d. Reimbursement for the injured worker eligibility evaluation is an all-inclusive rate for all professional provider and facility services.
2. Hospital-based inpatient chronic pain management services
 - a. Services provided by hospital-based inpatient programs shall be reported using ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting for hospital inpatient services.
 - b. Bills shall be submitted on the CMS-1450 (UB-04 Uniform Bill form).
 - c. Services shall be reimbursed according to the hospital inpatient reimbursement rule ([OAC 4123-6-37.1](#)).
3. Hospital-based outpatient chronic pain management services
 - a. Full and half day outpatient per diem services provided by hospital-based outpatient programs shall be reported with chronic pain program per diem codes listed in the hospital outpatient reimbursement rule (OAC 4123-6-37.2).
 - b. The unbundling of services by reporting CPT and HCPCS codes in place of per diem codes is prohibited.
 - c. Bills shall be submitted on the CMS-1450 (UB-04 Uniform Bill form).
 - d. Reimbursement for chronic pain program services under the full or half day outpatient per diem rate is an all-inclusive rate for all professional provider and facility services.
4. Free-standing outpatient chronic pain management services

- a. Full and half day outpatient per diem services provided by free-standing outpatient programs shall be reported with per diem codes listed in the professional provider and medical services reimbursement rule (OAC 4123-6-08).
 - b. The unbundling of services by reporting CPT and HCPCS codes in place of per diem codes is prohibited.
 - c. Bills shall be submitted on the CMS-1500 (Health Insurance Claim Form).
 - d. Reimbursement for chronic pain program services under the full or half day outpatient per diem rate is an all-inclusive rate for all professional provider and facility services.
5. Professional provider chronic pain management services
- a. Professional providers may not separately bill for services provided as part of chronic pain management program.
 - b. Reimbursement for services provided as part of a chronic pain management program are included in the hospital inpatient reimbursement rate or in the outpatient per diem rate (hospital outpatient or free-standing program).
6. Injured worker travel is reimbursed according to BWC's *Travel Reimbursement* policy and procedure (CP-20-01 and CP-20-01.PR1).

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Policy Name:	Opioid Use Disorder Treatment Coverage
Policy #:	BRM-07
Code/Rule Reference:	OAC 4123-6-21.7, 4123-6-37.1, 4123-6-37.2, 4123-6-08; 4123-6-10; 4123-6-06.2; 4123-6-40
Effective Date:	July 1, 2018
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding Opioid Use Disorder Treatment Coverage
History:	New
Review date:	07/01/2023

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the billing of opioid use disorder treatment directly supporting coverage as specified in Ohio Administrative Code 4123-6-21.7.

This policy defines when service limitations are applicable. It also provides multiple levels of reimbursable coverage on a continuum of care when the American Society of Addiction Medicine (ASAM) Criteria confirm the level of service required by the injured worker.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of opioid use disorder treatment within the Ohio Workers' Compensation System.

III. DEFINITIONS

Acute Inpatient detoxification: A level of care in which nursing services and medications are routinely administered under a physician's supervision to facilitate the patient's withdrawal from drugs. The following are features of this level of care:

- Most appropriate for more acute/severe cases with on-going issues;
- Patients require 24-hour care and medical monitoring;
- The patient is weaned off the opioid under direct medical supervision;
- Treatment in this setting typically lasts 3-10 days (but most often between 3 and 5 days);
- Main focus of care is medical monitoring for managing withdrawal; and
- American Society of Addiction Medicine (ASAM) Level 3.7 or 4.

American Society of Addiction Medicine (ASAM) Criteria: Treatment criteria for addictive, substance-related and co-occurring conditions. The criteria help providers make objective decisions to match a patient to the most appropriate level of care.

Intensive outpatient treatment (bundled): A level of care in which the patient receives part time, intensive treatment. The following are features of this level of care:

- Most appropriate for patients that do not require medically-supervised detoxification, or immediately following successful completion of detoxification;
- Allows patients to continue recovery therapies they learned and practiced while in a residential inpatient treatment center;
- Includes individual therapy, but is largely focused on group therapy;
- Patients must be in treatment for a minimum of 3 days a week for 3-4 hours per day;
- Treatment in this setting may extend from a few months to a year;
- Patients are encouraged to be a part of a 12-step program; and
- ASAM Level 2.1.

Opioid use disorder: A medical condition characterized by a problematic pattern of opioid use that causes clinically significant impairment or distress. A diagnosis is based on specific criteria such as unsuccessful efforts to cut down or control use, as well as use resulting in social problems and a failure to fulfill obligations at work, school, or home.

Outpatient individualized treatment (unbundled): A level of care in which the patient receives personalized services, including individual or group psychological/behavioral counseling, physician medication management, and laboratory testing and medications. The following are features of this level of care:

- Most appropriate for patients who have maintained sobriety for a period of time;
- The intensity of treatment is dependent upon the needs and motivation of the individual patient;
- Treatment in this setting is typically no more than 1-2 times per week for 1 hour (duration and frequency of the appointments can be adjusted as needed);
- Treatment is typically a non-programmatic unbundling of services delivered by different providers which might be coordinated through a case manager;
- Services are billed individually by each professional provider; and
- ASAM Level 1.

Partial hospitalization (bundled): A level of care in which the patient receives treatment for opioid use disorder as well as monitoring of psychiatric symptoms in an outpatient setting. The following are features of this level of care:

- Most appropriate for a patient who has completed inpatient detoxification and/or inpatient residential treatment;
- Less structured than an inpatient program but more structured than an intensive outpatient program;
- Strong focus on dual diagnosis and offers supervision and monitoring of psychiatric symptoms;
- Patients attend treatment sessions 5 to 7 days a week for more than 4 hours, up to 8 hours a day; and
- ASAM Level 2.5.

Prescriber: The physician (or treatment facility) that is responsible for directing and managing an injured worker's (IW) opioid treatment program.

Subacute inpatient detoxification: A level of inpatient care in which a patient's withdrawal from drugs is facilitated by utilizing primarily social interaction between

patients and staff in a supportive environment designed to facilitate safety for patients during recovery from the effects of withdrawal. Withdrawal medications are ordered by the physician and self-administered by the injured worker (IW), not staff. The following are features of this level of care:

- Patients are generally more stable than those in an acute inpatient detoxification program, but still require 24-hour medical monitoring for clinical management of withdrawal symptoms due to their higher risk for potential serious side effects;
- Programs may include medications, counseling and therapy sessions;
- Treatment in this setting typically lasts 3-10 days (but most often between 3 and 5 days);
- Physician evaluation and management services may be separately billable; and
- ASAM Level 3.5.

IV. POLICY

A. **IW Eligibility:** An injured worker is eligible for treatment for opioid use disorder when:

1. The IW has been prescribed opioids for treatment of an allowed condition for more than 12 weeks after the:
 - a. Date of injury or occupational disease; or
 - b. Surgery related to the allowed condition in the claim.
2. The IW agrees to discontinue opioid use and has requested treatment; and
3. The intent to discontinue opioid treatment is documented in the medical record.
4. The IW is not required to have a claim allowance for opioid use disorder (or an equivalent diagnosis such as opioid dependence) if treatment is being authorized pursuant to [OAC 4123-6-21.7](#), but the opioid use must be related to the industrial injury.

B. **Authorization for IW Assessment Prior to Treatment Plan Determination:** BWC requires the IW to be assessed prior to requesting or initiating treatment. The assessment:

1. Shall be authorized separately from the opioid use disorder treatment.
2. Shall be administered
 - a. at a licensed drug and alcohol clinic,
 - b. a psychiatric hospital, or
 - c. by an appropriately licensed provider whose scope of practice permits the provider to perform the assessment.
3. Shall be used to develop treatment recommendations including a determination of the most appropriate level of care using the application of the ASAM Criteria in effect on the date of the assessment as the basis for this determination.
4. Documentation shall include:
 - a. Patient history, including substance use history;
 - b. Family history;
 - c. Physical and mental status exam;
 - i. Physical manifestations of acute intoxication/withdrawal;
 - ii. Signs of any chronic illnesses;
 - iii. Symptoms and their relation to substance abuse;
 - d. Determination of disease morbidity;
 - e. Conclusion and diagnoses;

- i. In general, all IWs accepted for treatment must meet the diagnostic criteria for substance-related disorder;
- ii. Exceptions may be made for IWs whose symptoms are suggestive enough to warrant additional assessment;
- f. Evaluation of support system and vulnerabilities that might impact treatment;
- g. The use of an interdisciplinary team, if applicable;
- h. ASAM Criteria level; and
- i. Treatment recommendations.

C. Authorization of Opioid Use Disorder Treatment:

- 1. Following an assessment, treatment may be requested by:
 - a. The POR;
 - b. Treating physician; or
 - c. With a referral, the facility the treatment is being referred to.
- 2. The injured worker's treatment plan must correspond to the applicable ASAM level identified in the assessment.
- 3. The treatment period:
 - a. Shall begin on the IW's first date of treatment;
 - b. May include inpatient and/or outpatient treatment.
- 4. Opioid Use Disorder treatment will be limited as follows:
 - a. Eighteen months of treatment may be authorized and reimbursed pursuant to paragraph (F) of the rule [OAC 4123-6-21.7](#) following the initiation of the treatment period;
 - b. When placement for inpatient treatment is appropriate, the thirty days of inpatient treatment pursuant to paragraph (F) of the rule [OAC 4123-6-21.7](#) does not need to be consecutively rendered.
 - c. If opioid use disorder (or an equivalent diagnosis such as opioid dependence) is allowed in the claim, treatment is not subject to these time limits.

D. Noncompliance: Prescribers must proactively notify the MCO of evidence of non-compliance as documented within the medical file within 48 hours of determining an event of non-compliance.

E. Reimbursement of Opioid Use Disorder Treatment:

- 1. BWC reimburses for the treatment of opioid use disorder based on the BWC fee schedule:
 - a. In effect on the date of service, and
 - b. Corresponding to the applicable ASAM Criteria level of placement. (i.e. ASAM level 1, 2.1, 2.5, 3.5, 3.7, or 4).
 - i. BWC does not reimburse for ASAM levels not identified in the applicable fee schedule.
 - ii. Inpatient detoxification services (ASAM Levels 3.5, 3.7 or 4) are reimbursed pursuant to [OAC 4123-6-37.1](#) Payment of Hospital Inpatient Services;
 - iii. The all-inclusive, bundled programs - Intensive outpatient program and partial hospitalization (ASAM levels 2.1 and 2.5) are reimbursed pursuant to [OAC 4123-6-37.2](#) Payment of Hospital Outpatient Services;

BWC's Provider Billing and Reimbursement Manual

- iv. Outpatient individualized treatment (unbundled) (ASAM Level 1) is reimbursed pursuant to [OAC 4123-6-08](#) Bureau Fee Schedule;
 - c. Outpatient medication is:
 - i. Paid pursuant to [OAC 4123-6-21](#);
 - ii. Payable only to a BWC enrolled pharmacy; and
 - iii. Not payable to the treatment facility unless the treatment facility's pharmacy is BWC enrolled.
 - iv. Not payable for office-based dispensing of outpatient medication for medication management of opioid use disorder, including but not limited to:
 - a) Tablets, or
 - b) wafer/strips, or
 - c) other outpatient medication for medication management of opioid use disorder;
 - d) except for a monthly naltrexone injection which may be covered in the outpatient office setting as part of an MCO authorized treatment plan.
 - d. Physician services are separately billable in any level of care and are subject to reimbursement under [OAC 4123-6-08](#) Bureau Fee Schedule.
2. Where pursuant to the applicable fee schedule rule(s), the provider elects or is subject to an all-inclusive per diem service, BWC shall limit reimbursement to the per diem rate which is all-inclusive of the following services:
- a. Individual counseling or therapy;
 - b. Group counseling or therapy;
 - c. Education and support;
 - d. Biofeedback;
 - e. Stress management (e.g., counseling, aromatherapy, meditation, massage therapy, yoga);
 - f. Relapse prevention;
 - g. Recovery meetings;
 - h. Lab tests;
 - i. Crisis intervention;
 - j. Case management;
 - k. Pain management counseling;
 - l. Acupuncture;
 - m. Nursing support;
 - n. Dietary support or nutritional counseling;
 - o. Fitness counseling;
 - p. Peer support;
 - q. Individual or group activities (e.g., swimming, equine therapy, etc.);
 - r. Occupational and recreational therapies (e.g., art and music therapy);
 - s. Life skills training;
 - t. Any activity or amenity designed to facilitate an individual's success in the program;
 - u. Meals (if applicable for the level of care);
 - v. Semi-private room (if applicable for the level of care); and
 - w. Emergency access as defined by the ASAM Criteria level of care.
3. Pursuant to [OAC 4123-6-21.7](#)(F)(2)(c), prescriber documentation of three or more events of noncompliance by the IW, as described in Section IV. D. of this

policy, constitutes cause for termination of reimbursement of the opioid use disorder treatment.

- a. Documentation must be submitted by the injured worker requesting continued treatment.
- b. The prescriber and treatment facility will provide a recommendation regarding continuation of care.
- c. This information will be taken into consideration in determining the continuation or termination of reimbursement.

Policy Name:	Payment for Lumbar Fusion Surgery
Policy #:	BRM-08
Code/Rule Reference:	OAC 4123-6-32 , OAC 4123-6-32 Appendix , OAC 4123-6-33 , OAC 4123-6-16 , OAC 4123-6-08
Effective Date:	July 1, 2019
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding lumbar fusion surgery that predate the effective date of this policy.
History:	Rev. 07/01/2019; Rev. 10/1/2018; New 7/1/2018
Review date:	07/01/2024

I. POLICY PURPOSE: GENERAL OVERVIEW

Ohio Administrative Code (OAC) [4123-6-32](#) payment for lumbar fusion surgery - through this policy, BWC provides direction and clarification on the sixty day conservative care waiver, pre-surgical operating surgeon evaluations, pre-surgical health behavioral assessment, surgery request prerequisite documentation and after care requirements for lumbar fusion surgery services under the rule.

II. APPLICABILITY

This policy governs the application of [OAC 4123-6-32](#) paragraphs (A)(4)), (A)(2), (A)(3), and (D) to requests for lumbar fusion surgery received on or after the [OAC 4123-6-32](#) effective date.

III. DEFINITIONS

Health and Behavior Assessment: This is a procedure used to identify the behavioral, emotional, cognitive, and social factors important to the prevention, treatment, and/or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

Behavioral Barrier: Any identified factor that prevents the injured worker from adhering to treatment protocols or causes the injured worker to act in a manner which undermines the medical management and/or healing of an injured worker's allowed physical injuries, or that prevents the injured worker from effectively participating in the healing of the injured workers allowed physical injury. Examples of these barriers may be negative perceptions and expectations for recovery or disability which cause the injured worker to withhold important feedback needed by the physician in determining necessary medical treatment, or fear of re-injury which leads to the injured worker not adhering to a prescribed therapeutic treatment regimen.

IV. POLICY

A. Prerequisites to Consideration of Lumbar Fusion Surgery Waiver

Documentation:

In situations where the operating surgeon is requesting the prerequisites to consideration of lumbar fusion surgery requirements of [OAC 4123-6-32\(A\)\(1\)](#) to [\(A\)\(3\)](#) to be waived, the operating surgeon:

1. Must, at the time of the waiver request, submit medical documentation to justify the waiver; and
2. Must receive approval from the Managed Care Organization (MCO) for this waiver.

B. Pre-Surgical Operating Surgeon Evaluations:

1. Pursuant to paragraph [OAC 4123-6-32\(A\)\(2\)](#), the operating surgeon must evaluate the injured worker on at least two occasions prior to requesting surgical authorization, unless the prerequisites are waived pursuant to [OAC 4123-6-32\(A\)\(4\)](#).
2. If the prerequisites are not waived, at least one of the required evaluations should occur after the sixty (60) days of conservative care.

C. Pre-Surgical Health Behavior Assessment (HBA) for Lumbar Fusion

Services:

1. An injured worker's biopsychosocial factors that may affect treatment of the allowed lumbar condition must be considered prior to surgery per [OAC 4123-6-32\(A\)\(3\)\(f\)](#), unless the prerequisites are waived pursuant to [OAC 4123-6-32\(A\)\(4\)](#).
2. The health behavior assessment is not to be authorized, performed or reimbursed as a psychological evaluation.
3. Providers permitted to request HBA or HBAI services:
 - a) Either the POR or treating provider, or the operating surgeon may request HBA or HBAI services requested or performed in connection with lumbar fusion surgery pursuant to [OAC 4123-6-32](#).
 - b) In all other situations when HBA or HBAI services are needed, [OAC 4123-6-33](#) and subsequent Policy #[BRM-02](#) requires the POR to be the requestor of services.
4. For a lumbar fusion surgery, a health behavior assessment should be performed by an independent provider other than the provider of record (POR) or treating physician.
5. The HBA report must reflect:
 - a) Any behavioral barrier(s);
 - b) Their potential impact(s) on the healing of the allowed physical lumbar condition if present; and
 - c) Any recommended intervention services to address the identified barriers.
6. Identified barriers must be addressed with relevant interventional services prior to requesting lumbar fusion surgery.

D. Surgery Request Prerequisite Documentation:

1. When lumbar fusion surgery is requested, the operating surgeon shall provide documentation to support that all prerequisite rule requirements of [OAC 4123-6-32\(A\)](#) have been met, unless the prerequisites are waived pursuant to [OAC 4123-6-32\(A\)\(4\)](#).
2. The POR or treating physician and operating surgeon must effectively discuss lumbar fusion surgery outcomes with the injured worker prior to surgery.
3. The rule Appendix shall:
 - a) Be signed by the IW, and the POR, the treating physician, or the operating surgeon as an educational requirement acknowledgement for the injured worker.
 - b) Be provided to the MCO by the operating surgeon.

E. Lumbar Fusion Surgery After Care Requirements:

1. During the first six months post-operatively, maximum medical improvement for the allowed lumbar condition(s) must be documented by the operating surgeon with concurrence from the POR.
2. Postoperative visits rendered by the POR or treating physician and operating surgeon following lumbar fusion surgery shall not be subject to the sixty (60) day postoperative global surgical period identified in:
 - a) *BWC's Global Surgical Care for Professional Services policy*, and
 - b) The preamble to the Professional Provider Medical Services Fee Schedule [Appendix to OAC 4123-6-08](#).

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BWC's Provider Billing and Reimbursement Manual

Policy Name:	Telemedicine
Policy #:	BRM-09
Code/Rule Reference:	R.C. 4731.296, O.A.C 4123-6-02.2, O.A.C. 4731-11-09, O.A.C 4123-6-08; 4123-6-27
Effective Date:	October 1, 2018
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding Telemedicine that predate the effective date of this policy/procedure.
History:	New
Review date:	10/01/2023

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the authorization, billing and reimbursement of synchronous telemedicine services.

This policy defines reimbursement for synchronous, two-way, interactive videoconferencing as the modality by which telemedicine services are provided. The use of other modern technologies such as virtual reality, email, store and forward, e-consults without the injured worker (IW) present, remote monitoring devices are not included in this policy, however, may be otherwise covered and reimbursed through the BWC Professional Provider Fee Schedule.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of synchronous telemedicine services within the Ohio Workers' Compensation System.

III. DEFINITIONS

Asynchronous telecommunications (also known as store and forward telemedicine or non-interactive telecommunications): Medical information that is stored and forwarded to be reviewed at a later time by a health care provider at a distant site. Information may include, but is not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, lab results, audio clips and text.

Distant site: Location of the health care provider that is providing medical services. Authorized distant sites are health care provider offices or clinics, hospitals, critical access hospitals (CAHs), and skilled nursing facilities (SNFs).

Medical Peripherals: Any medical device that is attached to a computer externally such as pulse oximeters, weight scales, blood pressure cuff, stethoscope, etc.

Modifier 95: Modifier that denotes a synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

Originating site : Location where the IW is physically located at the time when services are being performed by a provider via audio and visual telecommunications. Authorized originating sites may be one of the following locations: health care provider clinic or office, hospital, critical access hospital (CAHs), skilled nursing facilities (SNFs), and an employer's secure, private location that allows an IW access to a remote provider.

Synchronous telecommunications: Live video conferencing: Medical information that is communicated in real-time with the use of interactive audio and video communications equipment. The real-time communication is between the IW and a distant health care provider who is providing the service.

Telehealth: A broad array of means or methods to enhance health care delivery and education through technology, including ehealth, mhealth applications, and distance education.

Telemedicine: A subset of telehealth, is defined as the delivery of health care services such as diagnosis, consultation, or treatment through the use of synchronous telecommunications, live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Telemedicine does not include the use of audio-only telephone, e-mail, store and forward, or facsimile.

Telepresenter: Medical professional with clinical background (e.g. medical assistant, LPN, RN, etc.) at the originating site that facilitates the visit, including the physical examination, at the direction of the distant site provider .

IV. POLICY

A. Licensure and Scope of Practice

1. Telemedicine providers shall comply with relevant licensing or certification laws in the jurisdiction:
 - a. Where the provider is physically located when providing telemedicine; **and**
 - b. Where the IW is physically located when receiving care.
2. Telemedicine providers must submit to the MCO proof of applicable licenses or certifications for all jurisdictions when requesting prior authorization or reimbursement for telemedicine services, including when an interstate licensure compact applies.
3. Providers of telemedicine services shall not:
 - a. Utilize telemedicine to expand the scope of practice of the health care provider; or
 - b. Practice in a jurisdiction where the provider does not have the required license or certification.
4. Telemedicine visits shall be held to the same standard of practice as those in traditional face-to-face settings (e.g. privacy, informed consent, medical documentation).

B. Location of Care for Telemedicine

1. An IW may receive medical care delivered through telemedicine provided the IW is located at an appropriate originating site, and the provider is at a distant site.

2. An originating site may be the IW's employer, but only when the employer provides a secure, private location that allows an IW access to a remote provider.
3. An originating site may not be the IW's residence, other than residence at a SNF or other long term care facility.

C. Provider Responsibilities

1. The telemedicine provider at the distant site must employ the use of a telepresenter when applicable, at the originating site to:
 - a. Facilitate the physical examination; and
 - b. Problem solve equipment and connectivity problems; and
 - c. Administer or apply the use of medical equipment when someone other than the IW must administer or apply.
2. Medical documentation shall clearly state:
 - a. The service was delivered by synchronous telemedicine;
 - b. When a telepresenter is used to assist with the physical examination at the originating site;
 - c. The originating site location: physical location of the IW (i.e. The IW was present at Dr. Smith's Office Practice at 123 Main Street, Columbus, Oh. for his/her telemedicine visit); and
 - d. The distant site location: physical location of the provider (i.e. the provider's servicing address).
3. Telemedicine providers shall be responsible for the telemedicine technology and security requirements for both the distant and originating site.
4. If the IW is presenting symptoms that are not appropriate for a telemedicine visit, the provider shall arrange within 24 hours :
 - a. A face to face visit with the IW; or
 - b. Refer and transfer care of the IW to a traditional brick and mortar provider if a face to face visit is not possible due to distance; or
 - c. Immediately refer the IW to appropriate emergency services when applicable.

D. Telemedicine Technology and Security Requirements

1. Technology requirements will apply to both the distant and originating site.
2. The telemedicine network and technology shall:
 - a. Be synchronous using interactive audio and visual telecommunications, permitting real-time communications between the distant site provider and the IW receiving health care services;
 - b. Utilize technically sufficient equipment and transmission speed to support the service provided:
 - i. Videoconferencing picture resolution, at a minimum, shall have a data rate of 30 frames per second (fps) with each frame containing 288 lines and 352 pixels per line.
 - ii. Telemedicine systems shall have a minimum of 384 kilobytes per second (Kbps) of bandwidth, and the distant site shall have the capacity to zoom and follow the IW at the originating site.
3. The originating site must have technology to support the telemedicine visit that:
 - a. Shall be stationary;
 - b. Shall connect to medical peripherals to facilitate a physical examination, when applicable;
 - c. Shall have a screen size equal to or greater than 12 inches diagonal;
 - d. Shall not be a cell phone.

E. Billing and Reimbursement

1. Telemedicine services are reimbursable pursuant to the Professional Provider Fee Schedule OAC 4123-6-08 in effect on the date of service.
 - a. Billing codes are limited to those with a -95 modifier in the fee schedule.
 - b. Place of service 02 must be used by the distant site provider in addition to the -95 modifier.
2. When prior authorization for a service is required pursuant to BWC's prior authorization requirements defined in the *Provider Billing and Reimbursement Manual*, the telemedicine provider must obtain prior authorization including when the service will be provided by telemedicine..
3. An originating site facility fee is payable to the originating site provider, except:
 - a. When the originating site is:
 - i. The employer;
 - ii. An inpatient hospital; or
 - iii. A SNF when the IW resides at the facility.
 - b. When the originating site:
 - i. Also billed for an evaluation and management service or other service provided to the same IW on the same day; and
 - ii. The distant site provider is part of the same group practice; and/or
 - iii. The distant site is not more than 25 miles from the originating site.
4. The following forms of technology and communication are not considered telemedicine and shall not be reimbursed as telemedicine services:
 - a. Telephone conversations;
 - b. Text messages;
 - c. Electronic mail messages;
 - d. Facsimiles (faxes);
 - e. Asynchronous or "store and forward" services;
 - f. Conversations between practitioners when the IW is not present.
5. Telemedicine services are not billable or reimbursable for the following:
 - a. Communication to the IW only to report results, provide education material, and/or address administrative matters;
 - b. Services that occur the same day as a face-to-face visit, when performed by the same provider and for the same condition;
 - c. Purchase, rental, installation or maintenance of telecommunications equipment or systems used in the delivery of telemedicine;
 - d. Provision of telemedicine using an unauthorized originating site;
 - e. Services provided in a jurisdiction where the health care provider does not have the required license or certification.
 - f. Multiple simultaneous sessions for different IWs by a single provider, other than group therapy.

BWC's Provider Billing and Reimbursement Manual

Policy Name:	OUTPATIENT MEDICATION PRIOR AUTHORIZATION PROGRAM
Policy #:	BRM-10
Code/Rule Reference:	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 and Appendix to the Formulary List of Medications Covered by BWC OAC 4123-6-21.4 – Coordinated services program OAC 4123-6-21.5 - Standard Dose Tapering Schedule and Appendix to Weaning List OAC 4123-6-21.6 - First Fill Program and Appendix to the First Fill Drug List OAC 4123-6-21.7 – Opioid Prescribing
Effective Date:	July 1, 2019
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding outpatient medication prior authorization programs.
History:	Revised 7/1/19; Republished 10/1/18
Review date:	7/1/2024

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the authorization and billing of outpatient medications.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of outpatient medications within the Ohio Workers' Compensation System.

III. DEFINITIONS

Compound prescription (sterile and non-sterile): A prescription that meets the following criteria: two (2) or more solid, semi-solid, or liquid ingredients, that are weighed or measured then prepared according to the prescriber's order and the pharmacist's art.

IV. POLICY

A. Outpatient Medication Coverage:

1. BWC shall only reimburse for:
 - a. Medications for the treatment of an allowed injury or illness;
 - b. Medications prescribed by the treating provider or physician of record;
 - c. Medications listed in the formulary appendix to [OAC 4123-6-21.3](#) or as otherwise provided by [OAC 4123-6-21.3](#); and
 - d. [Food and Drug Administration](#) approved legend and over-the-counter drugs.
2. The prescribing physician may verify the allowed conditions in a claim by visiting our website at www.bwc.ohio.gov or by calling 1-800-644-6292.

B. Pharmacy Benefits Manager (PBM)

1. BWC requires outpatient medication to be authorized and adjudicated through a PBM. The PBM:
 - a. Processes outpatient medication bills for state-fund, Black Lung and Marine Industry Fund claims;
 - b. Is a single source for accepting and adjudicating prescription drug bills;
 - c. Is separate from the Managed Care Organization (MCO).
2. The PBM's responsibilities are:
 - a. Performing on-line, point-of-service adjudication of outpatient medication bills with prescription information transmitted electronically between a pharmacy and PBM;
 - b. Enrolling pharmacy providers in a BWC-specific network;
 - c. Processing prescription bills based on the BWC closed formulary list of covered medications and restrictions;
 - d. Utilizing drug relatedness editing for prescribed medications; and
 - e. Performing desktop and on-site prescription audits of pharmacies.

C. Outpatient Medication Prior Authorization

1. BWC requires prior authorization for certain drugs not typically used to treat work-related injuries or illnesses when a condition is not allowed in the claim that supports the [Food and Drug Administration's](#) approved uses of that prescribed drug.
2. The prescribing physician must complete the [Request for Prior Authorization of Medication Form \(MEDCO-31\)](#) to request prior authorization.
3. BWC requires prior authorization for:
 - a. Medical Only claims beyond sixty (60) days from the date of injury;
 - b. All claims beyond two-hundred seventy (270) days of last paid prescription; and
 - c. A pending surgery:
 - i. To request pain medication or other post-surgically related medications subsequent to the MCO approval yet prior to the surgery date.
 - ii. The surgery date must be included on the [request](#) for consideration.
 - iii. A medication request of this type would be limited to a thirty (30) day fill.
4. To access BWC's formulary covered drugs, restrictions and prior authorization visit our website at <https://www.bwc.ohio.gov/provider/services/ICD10FormularyLookup/Default.aspx>.

D. Generic & Brand Name Drugs

1. An injured worker shall be subject to out-of-pocket cost liability when:
 - a. An injured worker requests a brand name drug. or
 - b. A physician specifies a brand name drug designated by "dispense as written" on the prescription for a medication, and
 - c. Single source or multi-source medications exist that are pharmaceutically and therapeutically equivalent.
 - d. In this circumstance, the injured worker shall be liable for the product cost difference between:
 - i. The established maximum allowable cost price of the drug product, and
 - ii. The AWP discounted rate of the dispensed brand name drug.
2. BWC may approve reimbursement of the dispensed brand name drug at the AWP discounted rate if:
 - a. The injured worker has a documented, systemic allergic reaction which is consistent with known symptoms or clinical findings of a medication allergy

- b. The injured worker has been prescribed, and has tried, other drugs in the therapeutic class and the intended therapeutic benefit has not been achieved or an unacceptable adverse event has occurred.

E. Injectable & Compounded Medication

- 1. Compounded medications have a National Drug Code (NDC) number for each ingredient that is included in the compounded product.
- 2. All compounded medications require prior authorization.
- 3. All outpatient sterile and non-sterile compounded medications shall be obtained from a licensed pharmacy provider.
- 4. The PBM point of sale system only reimburses:
 - a. For sterile compounds that are intended for use in pain pumps as part of the accepted claim conditions; and
 - b. An approved C-9 for pain pump implantation is required for reimbursement.

F. Billing

- 1. Existing Claims
 - a. A pharmacy provider is required to submit bills for outpatient medications at the point-of-service in all claims, including situations prior to assigning a BWC claim number. To submit a bill at the point-of-service, the pharmacist must transmit at least two (2) of the following three (3) items, along with the other billing information, to the PBM:
 - i. BWC claim number;
 - ii. Social Security number; and/or
 - iii. Date of injury.
 - b. The PBM shall verify the information, process the bill and send the pharmacist an appropriate message based on the claim's status, allowed conditions and formulary coverage and restrictions.
 - c. The PBM shall pay pharmacy provider bills according to OAC 4123-6-21.
- 2. First Fill Program:
 - a. BWC has established a program to provide reimbursement for the first fill of prescription drugs for medical conditions identified in a pending workers' compensation claim.
 - b. The program is limited to the first fill list ([click here](#)) of prescription drugs that occur prior to the date BWC issues an initial claim determination order.
 - c. Prescription reimbursement is limited to the following:
 - i. A period of ten (10) days or less at the most commonly prescribed dosing schedule, and no refills shall be approved;
 - ii. One (1) drug per therapeutic drug class listed in the appendix to OAC 4123-6-21.3;
 - iii. Extemporaneous compounded prescriptions are not eligible for reimbursement under the first fill program; and;
 - d. Prescription drugs not listed in the appendix to OAC 4123-6-21.3 are not eligible for reimbursement.
 - e. The prescribing physician or the prescribing physician's agent must write 'work-related injury' on and sign the prescription for the prescription to be eligible for the first fill program.
 - i. The pharmacist and pharmacy intern are permitted to write the phrase and sign telephone prescriptions.
 - ii. BWC shall guarantee payment for reimbursement for prescription drugs to a pharmacy provider when the first fill program requirements are followed, regardless of final claim acceptance or denial.
 - f. First fill prescriptions are reimbursed in the same manner as other prescriptions.

- i. The pharmacy provider should follow the steps outlined in Section IV.F.1 of this policy for billing guidelines.
 - ii. Custom messaging shall direct the pharmacy provider to resubmit the prescription after consulting the first fill medication list to ensure coverage.
 3. Durable Medical Equipment:
 - a. The PBM does not reimburse for durable medical equipment or medical supplies purchased at a pharmacy.
 - b. Durable medical equipment and medical supplies are subject to the BWC Professional Provider Fee Schedule OAC 4123-6-08,
 - c. Durable medical equipment and medical supplies must be billed to the MCO on the CMS-1500.
- G. Reimbursement Rates**
 1. Refer to OAC 4123-6-21 for reimbursement rates and/or calculations for state-fund employers for the following:
 - a. Single Source/Brand Drug;
 - b. Multi-Source/Generic Drug; and
 - c. Compounded product-dispensing fees for non-sterile and sterile compounds; and
 - d. The maximum reimbursement for any one (1) compounded prescription; and
 - e. The product cost component of payment for prescription drugs.
 2. BWC does not distinguish between legend and over the counter medications when determining reimbursement. Over the counter drugs must be prescribed by a provider licensed to prescribe medications for the drug to be considered for reimbursement.
- H. Supply & Quantity Limits** - BWC established maximum day supply and maximum quantity limits for both standard and catastrophic/chronic claim types.
 1. A standard claim can only receive the greater of a thirty-four (34) day supply or one-hundred twenty (120) units per dispensing.
 2. Catastrophic claims may receive up to a ninety (90) day supply with no quantity limitations.
- I. Payment for outpatient medication by a self-insuring employer**
 1. The PBM program defined in this policy **does not apply to self-insured employers.**
 2. Questions related to self-insured claims, including billing and reimbursement should be referred to the injured worker's employer.
 3. Payment for outpatient medication by a self-insuring employer will be made pursuant to OAC 4123-6-21.1.
- J. Forms**
 1. The prescribing physician uses the [MEDCO-31](#) form to request prior authorization for medications not typically used for industrial injuries or occupational disease. Please fax completed forms to 1-866-213-6066.
 2. The physician uses the [Formulary Medication Request Form \(MEDCO-35\)](#) to ask the Pharmacy & Therapeutics Committee to consider additions or deletions of a particular drug to the formulary.
 3. The injured worker uses the [Request for Injured Worker Outpatient Medication Reimbursement \(C-17\)](#) to obtain reimbursement for prescribed outpatient medication only.
 - a. This form is not used for medical supplies, durable medical equipment (e.g., crutches, walkers) and other non-drug items regardless of the prescribing provider.
 - b. The pharmacy provider is expected to submit bills electronically, even before the injured worker has a claim number.
 - c. The use of the [C-17](#) should be rare and limited to special circumstances.

- d. The completed [C-17](#) form shall be submitted to the PBM with the medication labels, pricing information or a pharmacy printout with pricing information and the pharmacist's signature.

K. **Contacts**

1. The PBM is prepared to answer technical support inquiries from the pharmacy provider and inquiries from the injured worker regarding the status of a submitted [C-17](#). To contact the PBM call 1-800-644-6292 and follow the prompts.
2. BWC Pharmacy Department: Providers, injured workers, employers and their representatives can inquire about the prior authorization program or other drug coverage related questions by calling 1-877-543-6446 and follow the prompts.
3. Questions and comments about pharmacy benefits should be emailed to the Pharmacy.Benefits@bwc.state.oh.us, by phone at 877-543-6556, or by mail to: Ohio Bureau of Workers' Compensation, Pharmacy Department, 30 W. Spring St. L-21, Columbus, OH 43215-2256.

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Policy Name:	Professional Provider Global Surgical Package
Policy #:	BRM-11
Code/Rule Reference:	OAC 4123-6-08 ; OAC 4123-6-32 ; OAC 4123-6-08 Appendix
Effective Date:	10/01/2018
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding global surgical care that predate the effective date of this policy.
History:	REVISED
Review date:	10/01/2023

I. POLICY PURPOSE

The purpose of this policy is to provide direction for the billing and reimbursement of surgical care for professional services when a global surgical period applies, including when more than one provider participates in the surgical care (pre-, intra- and post-operative).

II. APPLICABILITY

This policy applies to all actions relevant to the billing and reimbursement of surgical care within the Ohio Workers' Compensation System, as it relates to the global surgical period.

III. DEFINITIONS

Minor Procedure: Procedure codes with global surgery indicators of 010 in the Medicare National Physician Fee Schedule Relative Value File (PPRRVU) for the applicable calendar year.

Major Procedure: Procedure codes with global surgery indicator of 090 in the Medicare National Physician Fee Schedule Relative Value File (PPRRVU) for the applicable calendar year.

Preoperative Services: Services performed prior to surgery which may include, but are not limited to, medical examinations, diagnostic tests, medical management of underlying diseases, and counseling.

Intraoperative Services: Services performed that are normally a usual and necessary part of rendering the surgical procedure.

Postoperative Services: Services performed after surgery which include all additional medical or surgical supplies or services required of the surgeon during the post-operative period because of complications that do not require additional trips to the operating room. Includes follow-up visits that are related to the recovery from surgery and post-surgical pain management.

Global Surgery Package: Includes all the necessary services normally furnished and as stipulated in the definitions for preoperative, intraoperative, or postoperative services.

IV. POLICY

A. BWC follows the national established guidelines by Centers for Medicare and Medicaid Services (CMS) for global surgical package in effect on the date of service, except as follows:

1. Otherwise provided in Section IV. E. of this policy
2. BWC recognizes a sixty (60) day post-operative global surgical period instead of the CMS industry standard of ninety (90) days for major procedures.
3. Modifier reimbursement percentages.

B. Global Surgery Package Timeframe

1. BWC adheres to the global surgery package period for minor procedures as follows:
 - a. Preoperative – 0 days
 - b. Intraoperative – 1 day
 - c. Postoperative – 10 days
2. BWC adheres to a global surgery package period for major procedures as follows:
 - a. Preoperative – 1 day
 - b. Intraoperative – 1 day
 - c. Postoperative – 60 days

C. Reimbursement: BWC will reimburse the components of the global surgical package pursuant to the BWC Professional Provider fee schedule (Appendix to Ohio Administrative Code (OAC) [4123-6-08](#)) in effect on the date of service.

D. Billing for Split Surgical Care

1. BWC recognizes the national established guidelines by CMS for modifiers 54, 55, and 56 appended to a service to indicate when a physician furnishes only part of a global surgical package, and relinquishes the other portion(s) of the surgical package to another physician.
2. In any instance(s) where a physician furnishes part of a global surgical package, BWC requires all physicians involved in the injured worker's care to keep a copy of the written transfer of care agreement in the medical record.
3. The transfer of care shall be documented as indicating transfer of care by the surgeon to another physician(s), in the form of a letter or annotation in the medical note.
4. Surgical procedures performed in the Emergency Department (ED), place of service 23:
 - a. Modifier 54 must be appended to major surgical procedures performed in the Emergency Department (ED) place of service 23 for all professional services.
 - b. BWC will automatically append modifier -54 in major surgical cases where the modifier isn't appended.
5. The global surgical period does not apply:
 - a. When the surgical procedure was performed in the ED place of service; and

- b. When the provider rendering the follow up services is not the surgeon.
- c. This exception applies to both major or minor surgical procedures performed in the ED.

E. Lumbar Fusion Exception to Global: BWC exempts Evaluation and Management services rendered during lumbar fusion post-operative surgical care from the 60-day postoperative global surgery package period for major procedures, pursuant to OAC [4123-6-32](#).

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Policy Name:	Home Health Agency Services
Policy #:	BRM-12
Code/Rule Reference:	OAC 4123-6-38 ; 4123-6-08
Effective Date:	October 1, 2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding home health agency services.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	10/01/2022

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the authorization and billing of home health agency services, including home infusion therapy and hospice.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of home health agency services within the Ohio Workers' Compensation System.

III. DEFINITIONS

No definitions in this policy.

IV. POLICY

A. Eligible Providers - To be enrolled and certified by BWC, home health agencies must be either:

1. Certified by Medicare; or
2. Accredited by the Joint Commission; or
3. Accredited by Community Health Accreditation Program; or
4. Accredited through an organization granted deeming authority by Medicare.

B. Services

1. Skilled Nursing, Hourly Nursing, Home Health Aides, Therapists, and Social Workers
 - a. Billing for home health services must be submitted to the MCO on a CMS-1500 using the appropriate HCPCS Level I (CPT®) codes for physical, occupational or speech therapy and HCPCS Level II or BWC local level codes, listed in the [Professional Provider Fee Schedule](#), for other services including skilled nursing visits, hourly nursing, home health aide, and social worker visits.

- b. *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.*

2. Mileage and Travel Time

- a. The following codes are specific to services provided by home health agencies.
- i. **W2704** Home health agency worker providing direct care, mileage per mile, beginning with 51st mile round trip.
 - iii. **W2705** Travel time, home health agency professional worker each six (6) minutes
 - iv. **W2706** Travel time, home health agency non-professional worker each six (6) minutes
- b. The MCO shall select the BWC certified Home Health Agency that is closest to the injured worker's residence.
- i. Payment of mileage and/or travel time is limited to home health agency workers who are providing direct care to the injured worker.
 - ii. Mileage shall be reimbursed beginning with the 51st mile for a round trip for an injured worker.
 - iii. Mileage and time are calculated as follows:
 - a) Mileage and/or time calculation begins from home health worker's home base to injured worker home, and ends with return trip from injured worker home to home health worker's home base or next injured worker whichever comes first; or
 - b) Mileage and/or time begins from home health workers previous point of service to injured worker home and ends with return trip from injured worker home to home health worker's home base or next injured worker whichever comes first.
- c. *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.*

3. Home Infusion Therapy

- a. The MCO shall negotiate a per diem rate for all home infusion, therapy services while still maintaining high quality care for the injured worker. This rate shall include nursing services, medical supplies, medication and pharmacy services, unless otherwise noted. *(See IV.B.3.b.iii. below)*
- b. The all-inclusive per diem rates may be negotiated with the following BWC infusion pharmacy provider:
- i. A Medicare certified (i.e., issued by the Centers for Medicare and Medicaid Services directly or a Medicare 'deeming' organization) 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 shall include all services and supplies except for skilled nursing visits. The home health agency shall bill for each skilled nursing visit, and must be BWC certified.
 - c. The MCO's negotiated per diem rates shall 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. BWC recognizes the following BWC local level codes for billing of home infusion therapy:
 - i. W9010 - all-inclusive per diem, parenteral nutrition therapy;
 - ii. W9020 – all-inclusive per diem, enteral nutrition therapy;
 - iii. W9030 - all-inclusive per diem, antibiotic home infusion therapy;
 - iv. W9040 - all-inclusive per diem, pain management home infusion therapy;
 - v. W9050 - all-inclusive per diem, fluid replacement home infusion therapy;
 - vi. W9060 - all-inclusive per diem, chemotherapy home infusion therapy;
 - vii. W9070 - all-inclusive per diem, multiple home infusion therapies; and
 - viii. W9075 – home infusion therapy, includes nursing and medical supplies only.
- 4. Hospice Services**
- a. 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:
 - i. Request for hospice care must be at physician of record direction;
 - ii. The need for hospice care must be directly related to the claim allowance;
 - iii. The injured worker must be terminally ill with an estimated life expectancy of less than six (6) months;
 - iv. Aggressive treatment is no longer occurring. All future treatment shall be palliative (for the comfort of the patient).
 - b. Services shall receive authorization for no more than ninety (90) days at a time. All services and supplies must be provided for patient comfort rather than for treatment.
 - i. In home hospice care, that includes all services and supplies necessary for the injured worker's comfort may include nursing care, counseling services, massage, art, music, bereavement therapies, and supplies.
 - ii. 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.
 - iii. Acute hospice care **for symptom management** in hospice facilities or in nursing homes or hospitals with which the hospice provider has a contract to provide acute pain management services.
 - c. BWC shall reimburse for all services and supplies 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 the hospice provider meets all injured worker needs. BWC shall not approve additional home health services. The following codes are billed **to the MCO** by the hospice provider and then the hospice provider is responsible for reimbursing the nursing home, hospital, etc., with which it has a contract:

- i. Z0500 – in home hospice care per diem;
- ii. Z0550 – respite hospice care per diem; and
- iii. Z0560 – acute hospice hospital care for pain management per diem.

- C. **Billing Requirements** - Billing for home health services must be submitted to the MCO on a CMS-1500 using the appropriate HCPCS Level I (CPT®) or HCPCS Level II or BWC local level codes.

Policy Name:	Caregiver Services
Policy #:	BRM-13
Code/Rule Reference:	OAC 4123-6-38.1
Effective Date:	October 1, 2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding caregiver services.
History:	Reformatted 1/1/19, updated 10/1/17
Review date:	10/01/2022

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for the caregiver services eligible for reimbursement.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of caregiver services authorized prior to December 14, 1992 within the Ohio Workers' Compensation System.

III. DEFINITIONS

No definitions in this policy.

IV. POLICY

Caregiver Services

- A. A caregiver not employed by BWC certified home health agencies who was initially approved for services prior to December 14, 1992 (i.e., January 9, 1995 for spouse caregivers) may continue providing the services if approved by BWC.
- B. Billing must be submitted directly to BWC rather than to an MCO.
- C. The caregivers should not bill for dates the injured worker was hospitalized, as those dates are not reimbursable.
- D. The BWC Service Office assigned to the claim shall perform annual review and renewal of caregiver services authorization.
- E. 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.

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Policy Name:	Home and Vehicle Modifications
Policy #:	BRM-14
Code/Rule Reference:	OAC 4123-6-08 ; OAC 4123-6-02.21
Effective Date:	October 1, 2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding home and vehicle modifications.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	10/01/2022

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for home and vehicle modifications eligible for reimbursement.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of home and vehicle modifications authorized within the Ohio Workers' Compensation System.

III. DEFINITIONS

No definitions in this policy.

IV. POLICY

A. Home & Vehicle Modifications

1. 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 [Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease \(C-9\)](#) form processing periods, that the request is being forwarded to the specific BWC Catastrophic Nurse Advocate.
 - a. The BWC Catastrophic Nurse Advocate shall address all home and vehicle modification requests for all claims regardless if the equipment being requested is for a catastrophic claim and shall issue a determination.
 - b. The BWC Catastrophic Nurse Advocate shall work closely with the MCO case manager and the necessary vendors to ensure coordination of the services.
 - c. If the MCO receives a request for other services/supplies on the same [C-9](#), the MCO shall review and respond to the non-home and vehicle modification services request within the [C-9](#) processing timeframes.
2. The BWC Catastrophic Nurse Advocate is the primary authorization source for home and vehicle evaluations and modifications.

BWC's Provider Billing and Reimbursement Manual

- a. Reimbursement of home and vehicle modification services is made by either BWC or the MCO depending upon specific service and provider type.
 - b. Actual home and vehicle modifications are:
 - i. Performed by a vendor;
 - ii. Billed with a specific W code; and
 - iii. Paid by BWC.
 - c. Other services provided by a vendor require W codes for billing. These services are paid by BWC. *Exception:* Scooter/wheelchair lift and installation (i.e., 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.
 - d. Services billed by outpatient hospital (e.g., driving evaluations and driving training) require the use of revenue codes with appropriate CPT codes and are paid by the MCO.
 - e. Services billed by inpatient hospital require revenue codes only and are paid by the MCO.
3. 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 driving instructor	Non-facility	W0500	NA	By-Report	C-19 or CMS-1500 (for facility)	BWC
Description of Service	Provider Type	HCPCS/CPT ® Code	Revenue Code	Fee	Billing form	Bill To
Driving evaluation	Facility Outpatient	97003	OT	Hospital's outpatient reimbursement rate*	UB-04	MCO
Driving evaluation	Facility Outpatient	97001	PT	Hospital's outpatient reimbursement rate*	UB-04	MCO
Driving instruction for modified vehicle- PT, OT or certified driving instructor	Non-facility	W0549	NA	By-Report	CMS-1500	BWC

BWC's Provider Billing and Reimbursement Manual

Driving instruction for modified vehicle	Facility Outpatient	97535	PT	Hospital's outpatient reimbursement rate*	UB-04	MCO
Driving instruction for modified vehicle	Facility Outpatient	97535	OT	Hospital's outpatient reimbursement rate*	UB-04	MCO
Description of Service	Provider Type	HCPCS/CPT ® Code	Revenue Code	Fee	Billing form	Bill To
PT/OT evaluation for home/vehicle modification	Non-facility	W0678	NA	By-Report	CMS-1500	BWC
Home Modification (includes permanent ramp)	Vendor	W0675	NA	By-Report	C-19 or CMS-1500	BWC
Vehicle Modifications	Vendor	W0679	NA	By-Report	C-19 or CMS-1500	BWC
Home and Vehicle Modification Repairs	Vendor	W0677	NA	By-Report	C-19 or CMS-1500	BWC
Portable Ramp Rental or Purchase	Vendor	W0676	NA	Current BWC Fee Schedule	C-19 or CMS-1500	BWC
Lift, vehicle, 3-4 wheeled chair, with manual swing;	Vendor	W4000	NA	Current BWC Fee Schedule	C-19 or CMS-1500	MCO
Lift, vehicle, 3-4 wheeled chair, with motorized swing	Vendor	W4001	NA	Current BWC Fee Schedule	C-19 or CMS-1500	MCO

4. In order to differentiate between the types of scooter lifts that are available, BWC established the following codes:
 - a. W4000: Lift, vehicle, 3-4 wheeled chair, with manual swing; and
 - b. W4001: Lift, vehicle, 3-4 wheeled chair, with motorized swing.
5. BWC shall not reimburse a "deluxe" model of a scooter lift if the standard model provides the features that are medically necessary for the injured worker.
6. The MCO has 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 shall deduct the amount of the rebate from the established fee for the lift and installation.

B. Non-Covered Services

1. Non-Covered Services include:
 - a. Swimming pools of any type;
 - b. Hot tubs portable, freestanding or installed;
 - c. Spas portable, freestanding or installed;
 - d. Whirlpool baths portable, freestanding or installed;
 - e. Jacuzzis portable, freestanding or installed;
 - f. Central air conditioning or air-purification systems;
 - g. Dismantling of constructed ramp;
 - h. Removal, dismantling or transfer of home modifications;
 - i. Reimbursement of routine maintenance contracts; and
 - j. Home improvements that are of general utility and are not of direct medical benefit to the injured worker (i.e. carpeting, roof repair).
2. A portable whirlpool device put in the injured worker's tub can be approved/reimbursed by the MCO as durable medical equipment, if medically necessary and related to the allowed claim condition.

C. Home Modifications

1. BWC shall reimburse home modifications specifically needed by the injured worker due to physical limitations due to the result of allowed claim conditions.
2. BWC's fee cap for home modifications is forty-thousand (\$40,000) dollars.
3. BWC shall authorize home modifications on a one (1) time basis only. An exception would be for a ramp, which must be replaced if deterioration has occurred. Home modifications shall 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.
4. Bathroom - Only one bathroom shall be modified. Please contact BWC Catastrophic Nurse Advocate for specifics.
5. Kitchen - BWC may approve limited kitchen modifications for injured workers who are living alone. Please contact BWC Catastrophic Nurse Advocate for specifics.
6. 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.
7. 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 shall reimburse the percentage of cost for air conditioning for the injured worker's room only. BWC shall 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.

8. Handicap Accessible Home – If the injured worker chooses to purchase a new handicap accessible home, BWC shall 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 shall be made after the house is built and the injured worker furnishes a copy of the deed/closure documentation showing ownership.
9. 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 shall not accommodate a stair-lift. **Elevators should only be approved when there are no other alternatives.** Stair-lifts are not approved for basement access.
10. Ceiling installed lift tracking mechanism – The injured worker must ensure that the home structure can accommodate this equipment.

D. Vehicle Modifications

1. BWC requires a physician prescription or [C-9](#) from the physician of record for vehicle modifications and driving evaluation and training, if needed, stating medical necessity and the relationship to the allowed condition.
2. A complete driving evaluation for initial vehicle modifications by a certified driving instructor is also required.
 - a. A vehicle modification, shall be considered by, the BWC Catastrophic Nurse Advocate, 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.
 - b. BWC shall modify one (1) vehicle only. The same vehicle shall be modified for the lifetime of vehicle. If an injured worker owns more than one (1) vehicle, the injured worker is responsible for modification of any additional vehicles.
 - c. The injured worker must undergo a driving evaluation if the vehicle is to be driven by the injured worker. BWC may require a second driving evaluation if there is a change in the injured worker's condition.
 - d. BWC shall limit reimbursement to modification/equipment specifically needed by the injured worker. BWC shall 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.

- e. 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.
- f. BWC shall not pay for purchase of the vehicle to be modified.
- g. BWC may authorize manual wheelchair carriers (e.g., car topper) for paraplegics who can transfer.
- h. 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.
- i. BWC shall reimburse for reasonable vehicle modification repairs, not routine maintenance of modified vehicles.
- j. The injured worker is responsible for a yearly maintenance on lifts or mechanical parts.
- k. Repairs of two-hundred fifty (\$250) dollars or less do not require prior authorization by the BWC Catastrophic Nurse Advocate.
- l. Repairs with an estimated cost greater than two-hundred fifty (\$250) dollars require authorization by the BWC Catastrophic Nurse Advocate in advance unless done in emergency situation.

BWC's Provider Billing and Reimbursement Manual

Policy Name:	Interpreter Services
Policy #:	BRM-15
Code/Rule Reference:	OAC 4123-6-08 ;
Effective Date:	October 1, 2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding interpreter services.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	10/01/2022

I. **POLICY PURPOSE**

The purpose of this policy is to ensure that BWC provides direction for interpreter services eligible for reimbursement.

II. **APPLICABILITY**

This policy applies to all actions relevant to the request, approval and reimbursement of interpreter services authorized within the Ohio Workers' Compensation System.

III. **DEFINITIONS**

No definitions in this policy.

IV. **POLICY**

Interpreter Services

- A. It is the policy of BWC to provide necessary and appropriate interpreter services for injured workers. 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.

- B. American Sign Language interpreters shall 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 shall not be provided for the above services and no interpreters shall be provided for hospital based services, unless, after the BWC Claims Service Specialist or Disability Management Coordinator staffs the case with Claims, Medical or Rehab policy, an unusual situation exists which makes providing an interpreter necessary and appropriate.

- C. Frequently, the injured worker shall 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 injured worker 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 shall refer the need to the assigned BWC Claims Service Specialist or Disability Management Coordinator, who in consultation with the MCO shall determine what is "necessary and appropriate." The BWC Claims Service Specialist or Disability Management Coordinator 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.
- D. Please contact the MCO, BWC Claims Service Specialist or Disability Management Coordinator to request an interpreter. The assigned BWC Claims Service Specialist or Disability Management Coordinator is responsible for reviewing and approving interpreter services.
- E. Interpreters For Hospital-Based Services**
1. Interpreter services in a hospital-based setting are the responsibility of the hospital.
 2. If the injured worker has been approved for hospital-based services and the BWC Claims Service Specialist or Disability Management Coordinator is aware that interpreter services shall be required, the BWC Claims Service Specialist or Disability Management Coordinator 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 BWC Claims Service Specialist or Disability Management Coordinator may also request that the hospital notify them if interpreter services shall be required soon after the injured worker is discharged.
- F. Interpreters for Vocational Rehabilitation**
1. When an injured worker is participating in vocational rehabilitation and it appears interpreter services shall be required, the vocational rehabilitation case manager, MCO designee and BWC Disability Management Coordinator must staff the plan in advance.
 2. The BWC Disability Management Coordinator has the responsibility to approve or disapprove the services prior to plan implementation.
 3. 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.

G. *Payment For Interpreter Services - Family members, friends, medical, health care and vocational providers and/or community volunteers may provide interpretation for injured workers but are not eligible for enrollment or reimbursement.*

1. BWC Medical Billing & Adjustments

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

2. Billing Instructions, Codes & Fees

- a. **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.
- b. Reimbursement shall be at the provider billed amount or at the BWC fee, whichever is lower.
- c. Inquiries about unresolved billing issues should be directed to BWC's Provider Contact Center at 1-800-644-6292.
- d. Bills must be submitted on BWC's [C-19](#) Service Invoice. The provider of interpreter services may obtain a [C-19](#) from the BWC staff who requested these services
- e. **All Interpreter Services (BWC or IC) must be billed with the appropriate code(s) listed below on a [C-19](#).**
 - i. **W1930** - Interpreter Services, per fifteen (15) minutes.
 - ii. **W1931** Interpreter Wait Time, per six (6) minutes, Maximum of 30 minutes per date of service (including waiting for an injured worker that does not show up for appointment).
 - iii. **W1932** - Interpreter Travel Time, per six (6) minutes (including travel time for an injured worker that does not show up for appointment).
 - iv. **W1933** - Interpreter Mileage, per mile.

3. Enrollment Of Providers Of Interpreter Services

- a. The provider delivering Interpreter Services for BWC and IC approved services shall be enrolled as provider type 99 (other).
- b. When an MCO requests enrollment of the interpreter, the MCO must include the vocational rehabilitation plan approved by the BWC Disability Management Coordinator with a non-certified enrollment form.
- c. The provider of Interpreter Services may enroll using the [Application for Provider Enrollment and Certification \(Medco-13A\)](#) form found on the Web site at <https://www.bwc.ohio.gov/bwcccommon/forms/BWCForms/nlbwc/ProviderForms.asp>.

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Policy Name:	Catastrophic Case Management Plan
Policy #:	BRM-16
Code/Rule Reference:	OAC 4123-6-08
Effective Date:	10/1/2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding a catastrophic case management plan.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	10/01/2022

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for catastrophic case management plan services eligible for reimbursement.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of a catastrophic case management plan authorized within the Ohio Workers' Compensation System.

III. DEFINITIONS

No definitions in this policy.

IV. POLICY

Catastrophic Case Management Plan (*Previously Called Life Care Plan*)

A. The Health Partnership Program places emphasis on a consistent, cooperative approach to catastrophic case management by the MCO and BWC. Each catastrophic claim is different, which necessitates highly individualized management.

The Catastrophic Case Management Plan shall be considered and reviewed, with the BWC Catastrophic Nurse Advocate, for appropriateness on catastrophic claims that are chronic and result in a disabling condition greater than one (1) year. A Catastrophic Case Management Plan is not appropriate for injured workers residing in assisted living facilities, nursing homes or Brain Injury Rehabilitation facilities as there is usually a plan of care developed by the facility. Catastrophic Case Management Plans are to be used as tools to assist in the ongoing medical management of a catastrophic injury.

B. 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 Manager and/or the BWC Catastrophic Nurse Advocate should staff family members' concerns and may discuss them with the employer to see if the employer is willing to pay for crisis intervention.

- C. The MCO's Catastrophic Case Manager and the assigned BWC Catastrophic Nurse Advocate determine the necessity for a Catastrophic Case Management Plan. All conditions allowed in the claim shall be addressed on the Catastrophic Case Management Plan 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.
- D. **The Catastrophic Case Management Plan must be completed within sixty (60) days of referral from the MCO to the provider.**
The Catastrophic Case Management Plan shall include at the beginning of the report that **all services in the plan are subject to BWC and MCO policy and based upon medical necessity.** The provider writing the Catastrophic Case Management Plan shall work with the BWC Catastrophic Nurse Advocate and the MCO and be familiar with the unique differences required for providing a Catastrophic Case Management Plan. All Catastrophic Case Management Plans must be reviewed with the BWC Catastrophic Nurse Advocate before they are discussed with the injured worker or the injured worker's family and before implementation.
- E. The Catastrophic Case Management Plan 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. **The Catastrophic Case Management Plan must be billed using BWC local level code Z1000 at one-hundred (\$100.00) dollars per hour, not to exceed four-thousand (\$4,000.00) dollars. The Catastrophic Case Management Plan shall be billed one (1) time only, using the completion date as the date of service.**
- F. For a provider to provide Catastrophic Case Management Plan services the provider must possess at least one (1) of the following credentials and shall be enrolled as a provider type 76:
1. Certified Occupational Health Nurse;
 2. Certified Rehabilitation Counselor;
 3. Certified Insurance Rehabilitation Specialist;
 4. Certified Vocational Evaluator;
 5. Certified Rehabilitation Registered Nurse;
 6. Certified Case Manager; and/or
 7. Certified Disability Management Specialist. or
 8. These credentials alone do not automatically qualify a provider to complete a Catastrophic Case Management Plan. The MCO shall be responsible for choosing a BWC certified provider that is a certified Life Care Planner or has experience developing quality Life Care Plans. The MCO should discuss with the provider the details of the Catastrophic Case Management Plan, as found in the MCO Policy Reference Guide, prior to the start of the plan.

Policy Name:	Exposure or Contact with Blood or Other Potentially Infectious Materials with or without Physical Injury
Policy #:	BRM-17
Code/Rule Reference:	ORC 4123.01; ORC 4123.026
Effective Date:	08/07/2015
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding exposure that predate the effective date of this policy.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	10/01/2022

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for exposure claim services eligible for reimbursement.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of medical services in exposure claims allowed within the Ohio Workers' Compensation System.

III. DEFINITIONS

No definitions in this policy.

IV. POLICY

A. Exposure Claim Processing

1. BWC generally does not allow a claim for exposure/contact with blood or other potentially infection materials because an accompanying physical injury or occupational disease has not occurred.
2. In cases where there is physical injury evidence or if a worker contracts a disease after exposure and compensability is established, medical costs may be reimbursed. In certain vocations there are exceptions made in the law to pay costs of post-exposure medical diagnostic services.

- B. "Exposure to Blood or Other Potentially Infectious Materials" Policy & Procedures** - The "Exposure to Blood or Other Potentially Infectious Materials" [\(click here\)](https://www.bwc.ohio.gov/basics/policylibrary/FileShell.aspx?file=%2fClaims+Policy%2fExposure.htm) policy and procedures provide details of these scenarios and are located on our website policy section at :
<https://www.bwc.ohio.gov/basics/policylibrary/FileShell.aspx?file=%2fClaims+Policy%2fExposure.htm>

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Policy Name:	Spinal Decompression Therapy
Policy #:	BRM-18
Code/Rule Reference:	OAC 4123-6-08
Effective Date:	October 1, 2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding spinal decompression therapy.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	10/01/2022

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for spinal decompression therapy services eligible for reimbursement.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of spinal decompression therapy authorized within the Ohio Workers' Compensation System.

III. DEFINITIONS

No definitions in this policy.

IV. POLICY

- A. **Billing** - BWC requires spinal decompression therapy be billed with the CPT code 97012 for mechanical traction and shall pay one (1) unit of service per visit, regardless of the length of time the traction is applied.
- B. **Decision** - The decision regarding authorization of decompression therapy shall remain with the individual MCO.
- C. **Intent Of Decompression Therapy** - 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.

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Policy Name:	Smoking Deterrent Programs
Policy #:	BRM-19
Code/Rule Reference:	OAC 4123-6-08 ; OAC 4123-6-07
Effective Date:	October 1, 2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding smoking deterrent programs.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	10/01/2022

I. POLICY PURPOSE

The purpose of this policy is to ensure that BWC provides direction for smoking deterrent programs eligible for reimbursement.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of smoking deterrent programs authorized within the Ohio Workers' Compensation System.

III. DEFINITIONS

No definitions in this policy.

IV. POLICY

A. **Responsibility** - BWC and the MCO responsible for medically managing a claim may consider reimbursement of an MCO approved/accredited smoking cessation program with or without [Food and Drug Administration](#) 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.

B. Reimbursement Of Smoking Cessation Programs

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

1. **W5000** - Monitored smoking cessation program **with the** [Food and Drug Administration](#) 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.

2. **W5001** - Monitored smoking cessation program **without the [Food and Drug Administration](#)** 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.

C. Non-Covered Services

1. BWC does not reimburse prescription smoking deterrent drugs outside an approved smoking cessation program, except when dispensed while the injured worker is admitted to a hospital during an approved inpatient admission or during the course of an outpatient visit in a hospital. See [OAC 4123-6-07\(D\)](#) BWC's Pharmacy Benefits Manager shall not reimburse smoking deterrent drugs.
2. Smoking deterrent drugs that are not [Food and Drug Administration](#) approved shall not be reimbursed and shall not be billed to BWC or the MCO.

- D. Provider Enrollment & Billing** - The provider of a smoking cessation program is required to enroll as BWC certified provider and to bill for services on the CMS-1500. The bills must then be submitted to the managing MCO for reimbursement.

BWC's Provider Billing and Reimbursement Manual

Policy Name:	Traumatic Brain Injury (TBI)
Policy #:	BRM-20
Code/Rule Reference:	ORC 4123.05; OAC 4123-6-02.2; OAC 4123-6-08
Effective Date:	June 1, 2017
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding traumatic brain injury.
History:	Reformatted 1/1/19; updated 10/1/17
Review date:	7/01/2020

I. **POLICY PURPOSE**

The purpose of this policy is to ensure that BWC provides direction for traumatic brain injury services eligible for reimbursement.

II. **APPLICABILITY**

This policy applies to all actions relevant to the request, approval and reimbursement of traumatic brain injury services authorized within the Ohio Workers' Compensation System.

III. **DEFINITIONS**

No definitions in this policy.

IV. **POLICY**

- A. **Definition** - TBI is an injury to the head arising from a blunt or penetrating trauma or from acceleration or deceleration forces.
- B. **Purpose** - The TBI section of this manual covers "non-hospital based" brain injury rehabilitation billing codes and services. For hospital-based brain injury services please see the inpatient and outpatient hospital sections of this manual.
- C. **Accreditation** - BWC requires all non-hospital based brain injury facilities to be accredited by the Commission on Accreditation of Rehabilitation Facilities for brain injury services.
- D. **Certification** - Brain injury rehabilitation facilities must be BWC certified; however, the MCO may approve treatment at a facility that is enrolled but not certified if the MCO determines no BWC certified facility is available.
- E. **Non-Hospital Based TBI Facilities** - Non-hospital based brain injury rehabilitation facilities should be BWC certified and enrolled as a type 82 provider (i.e., reference the BWC Provider Enrollment form, type 82 provider).

F. Types Of Brain Injury Rehabilitation Facilities:

1. **A post-acute, brain injury rehabilitation facility** is a facility that provides residential and/or outpatient post-acute rehabilitative care serving an injured worker who no longer require acute comprehensive inpatient care and is physically capable of participating in a brain injury rehabilitation program. Services provided in a post-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 12-18 month duration.
A neurobehavioral, brain injury facility is a post acute rehabilitation facility (as defined above) that additionally provides post-acute neurobehavioral rehabilitation for the individual with a brain injury who is exhibiting maladaptive behavior and changes in personality.
2. **A transitional living placement facility** is a facility that provides short-term reintegration services for the injured worker to transition into the community. These facilities may provide occupational therapy, physical therapy, speech therapy, job coaching, job development and job placement as appropriate for the injured worker.
3. **A lifelong living TBI facility** is a facility that provides long-term residential living services for an injured worker who is not able to return independently to the workforce and/or community.

G. Authorization & Documentation Requirements - The following requirements are applicable to non-hospital based post-acute brain injury rehabilitation facilities:

1. It is a requirement that all brain injury, rehabilitation services receive preauthorization from the MCO. Approval for non-hospital based rehabilitation requires that a screening evaluation be performed that includes an analysis of the injured worker's mental, emotional, social and physical status and function. The report should substantiate the injured worker needs for the particular facility and the services being requested. The work that may be necessary to complete the screening evaluation is considered part of the facility's administrative overhead for appropriateness of acceptance of the injured worker to the injured worker's facility.
2. Documentation must be submitted at least monthly or per the frequency required by the MCO for injured worker in post-acute, neurobehavioral or transitional living brain injury rehabilitation facilities. Medical documentation shall include, but is not limited to, the following:
 - a. Initial treatment plan and/or status of treatment goals;
 - b. Treatment history and expected discharge outcomes, to include projected discharge date and the anticipated discharge placement;
 - c. Treatment team members and the number of hours the injured worker spends with the treatment team members;
 - d. Treatment progress summary and comparison/progress from previous reports;
 - e. Test results and cognitive function assessment/scale (e.g., Ranchos Los Amigos or Glasgow Coma scale), medical problems and how these relate to treatment; and
 - f. Family interaction, as appropriate.
3. Documentation must be submitted for lifelong living TBI residential services bi-annually or sooner if requested by the MCO.

- H. **Non-Hospital Based Facilities Billing & Reimbursement Codes** - The “non-hospital based” facilities use local billing codes. To find the current BWC reimbursement rates, please refer to the [BWC Fee Schedule](#). The billing codes and service descriptions are as follows:
1. TBI local level BWC codes:
 - a. W0177 is billed for the reimbursement of post-acute brain injury residential rehabilitation services, all-inclusive daily rate.
 - b. W0178 is billed for the reimbursement of neurobehavioral residential brain injury rehabilitation services, all-inclusive daily rate.
 - c. W0179 is billed for the reimbursement of post-acute outpatient brain injury rehabilitation services (full day/6 hour minimum), all-inclusive daily rate.
 - d. W0181 is billed for the reimbursement of post-acute outpatient brain injury rehabilitation services (half day/3 hour minimum), all-inclusive daily rate.
 - e. W0182 is billed for the reimbursement of lifelong living brain injury residential rehabilitation services, all-inclusive daily rate.
 - f. W0183 is billed for TBI in house pharmacy services.
 - g. W0184 is billed for TBI therapeutic leave of absence, twenty-five percent (25%) of daily rate.
 - h. W0185 is billed for the reimbursement of transitional living services.
 2. Post acute brain injury rehabilitation, neurobehavioral, and transitional living services are billed as an all-inclusive code that shall include the following as determined necessary:
 - b. Room and board;
 - c. Restorative services such as physical therapy, occupational therapy, and speech therapy;
 - d. Psychotherapy;
 - e. Group therapy;
 - f. Recreational therapy (including group outings);
 - g. Behavioral counseling;
 - h. Vocational counseling;
 - i. Nursing and case management services;
 - j. Team conferences;
 - k. Report preparation;
 - l. Pharmacology management;
 - m. Medical management;
 - n. Appropriate level of direct and indirect supervision (including one-on-one sitter services in a neurobehavioral brain injury facility);
 - o. Nutritional and dietary monitoring;
 - p. Structured schedule for activities of daily living; and
 - q. Family involvement, which may include home visits and phone contacts.
 3. The daily per diem rate for residential post-acute TBI rehabilitation services does not cover:
 - b. Physician fees;
 - c. Prescription medications;
 - d. Durable medical equipment; and
 - e. Medical services (i.e., labs or radiology or driver's evaluations).

4. One-on-one sitter services may be provided as a separate service in a non-neurobehavioral environment, but must be pre-authorized. If one-on-one sitter services are required, the MCO shall evaluate and determine the appropriate service facility.
5. Lifelong living TBI residential programs are billed as an all-inclusive code that should include the following:
 - a. Room and board;
 - b. Nursing and staff oversight;
 - c. Case management; team conferences and report preparation;
 - d. Recreational activities, including group activities;
 - e. Group therapy;
 - f. Pharmacology management;
 - g. Nutritional and dietary monitoring;
 - h. Assistance with activities of daily living; and
 - i. Family involvement, which may include, home visits and phone contracts.
6. The daily per diem rate for lifelong living TBI residential programs does not include:
 - a. Physician fees;
 - b. Individual physical and occupational therapy;
 - c. Individual speech therapy and behavioral therapy;
 - d. Prescription medications;
 - e. Durable medical equipment; and
 - f. Medical services (e.g., lab or radiology).
1. Lifelong living residential services, other than the TBI facilities, are billed using the appropriate residential fee code. This includes residential care/assisted living facilities and skilled nursing facilities.

I. Outpatient Brain Injury Rehabilitation/Day Treatment Programs

1. Post acute facilities (i.e., type 82 providers) that provide outpatient, day treatment programs shall use local billing codes to bill for service.
2. Full day, outpatient program reimbursement must be a minimum of six (6) hours and half-day programs must be a minimum of three (3) hours of integrated services as described below.
3. Day programs are billed as an all inclusive daily rate that includes any of the following:
 - a. Medical director/physiatry;
 - b. Physical therapy and occupational therapy;
 - c. Speech and language therapy;
 - d. Psychotherapy;
 - e. Neuropsychiatry;
 - f. Neuropsychology;
 - g. Behavioral analysis, behavior modification and counseling;
 - h. Group therapy;
 - i. Substance abuse counseling;
 - j. Recreational therapy;
 - k. Vocational services and job coaching;
 - l. Rehabilitation case manager;
 - m. Nursing and pharmacology management;
 - n. Brain injury specialist; and/or

- o. Follow-up interviews with family, which may include, home visits and phone contacts.
- 4. Therapies, treatments and/or services are included in the per diem rate and are not billed separately.

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BWC's Provider Billing and Reimbursement Manual

Policy Name:	Applicability of Medical Documentation Submitted by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants
Policy #:	BRM-21
Code/Rule Reference:	R.C. 4123.56, 4723.42, 4723.43, 4730.08, 4730.20, O.A.C 4123-5-18, 4123-6-20
Effective Date:	06/01/17
Approved:	Freddie L. Johnson, Chief of Medical Services
Origin:	Medical Policy
Supersedes:	All medical policies and procedures, directives and memos regarding the Certification of Periods of Disability by Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants.
History:	Reformatted 1/1/19; Rev. 06/01/17; New 02/26/16
Review date:	02/26/20

I. POLICY PURPOSE

The purpose of this policy is to provide direction to medical providers, BWC staff and Managed Care Organizations (MCOs) on the applicability of medical documentation submitted by different provider types that is used as supporting evidence in certifying periods of temporary total disability.

II. APPLICABILITY

This policy applies to BWC staff, MCOs, and providers.

III. DEFINITIONS

Certified nurse practitioner (CNP): A registered nurse holding a license to practice as a CNP from the Ohio Board of Nursing or equivalent, authorized to practice in collaboration with one or more physicians. A CNP may provide preventative and primary care services, provide services for acute illnesses, and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification, and in accordance with rules adopted by the nursing board. A CNP who holds a certificate to prescribe may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices.

Clinical nurse specialist (CNS): A registered nurse holding a license to practice as a CNS from the Ohio Board of Nursing or equivalent, authorized to practice in collaboration with one or more physicians. A CNS may provide and manage the care of individuals and groups with complex health problems and provide health care services that promote, improve, and manage health care within the nurse's nursing specialty, consistent with the nurse's education and in accordance with rules adopted by the nursing board. A CNS who holds a certificate to prescribe may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices.

Physician assistant (PA): A skilled person holding a license to practice as a PA from the State Medical Board of Ohio or equivalent, qualified by academic and clinical training to provide services to patients under the supervision, control and direction of one or more physicians with whom the physician assistant has entered into a supervision agreement approved by the state medical board and who are responsible for the PA's performance.

Physician extender (PE): For purposes of this policy, a physician extender is a certified nurse practitioner, clinical nurse specialist or physician assistant.

IV. POLICY

- A. It is BWC's policy to recognize, the following as authorized to take action as outlined in section IV.B., below:
 - 1. Physicians, or
 - 2. PEs, only:
 - a. During the first six weeks after the date of an injury, for no more than six weeks of disability, or
 - b. With the co-signature of a physician.

- B. The authorized individuals as noted in section IV.A., above, may do any of the following:
 - 1. Examine the injured worker (IW);
 - 2. Submit medical documentation BWC may use to support an IW's temporary total disability due to an allowed work-related injury or disease;
 - 3. Complete and submit a MEDCO-14 form or its equivalent; and
 - 4. Submit a detailed return to work (RTW) plan.

- C. BWC does not authorize PEs to:
 - 1. Submit medical documentation which may be utilized to support any type of compensation other than temporary total disability;
 - 2. Work outside the scope of their collaborative or supervisory agreement;
 - 3. Be granted Physician of Record (POR) status; or
 - 4. Be granted the status of a Disability Evaluators Panel (DEP) physician.

V. PROCEDURE

- A. Before awarding the initial period of temporary total disability, BWC shall ensure that the physician or PE has:
 - 1. Examined the IW;
 - 2. Completed, signed and submitted the MEDCO-14 or equivalent;
 - a. The PE may sign and submit a MEDCO-14 or equivalent, which may be utilized to support temporary total disability without a physician signature during the first six weeks after the date of injury, and for no more than six weeks of disability;
 - b. Following the period specified in V.A.2.a. above, the PE may sign and submit a MEDCO-14 or equivalent, which may be utilized to support temporary total disability only with the co-signature of a physician;
 - c. At any point in the life of the claim, a MEDCO-14 or equivalent signed only by a physician may be utilized in support of temporary total disability
 - 3. Completed a detailed treatment and RTW plan.

- B. If an initial period of TT is granted based upon a MEDCO-14 or equivalent signed only by a PE, prior to the conclusion of that initial period BWC shall inform the IW that ongoing requests for TT must be supported with medical documentation signed or co-signed by a physician (not a PE only).
- C. If a PE renders treatment for periods of TT beyond the initial six weeks following the date of injury, BWC shall ensure that the supporting medical documentation indicates that:
 - 1. The PE and/or physician has examined the IW; and
 - 2. A physician co-signature is on the MEDCO-14 or equivalent if such medical documentation is being used to extend an injured worker's periods of disability.
- D. BWC shall ensure that medical documentation supporting an IW's RTW is signed by:
 - 1. A physician; or
 - 2. A PE:
 - a. Independently, when the RTW occurs within the initial six-week period immediately following the date of injury; or
 - b. With a physician co-signature, when the RTW occurs after the initial six-week period immediately following the date of injury.
- E. Please refer to *Temporary Total Compensation* policy and procedure for further guidance on the payment of this type of compensation.

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Policy Name:	DOCUMENTATION OF TIMED SERVICES
Policy #:	BRM-22
Code/Rule Reference:	OAC 4123-6-04.4 ; OAC 4123-6-08 ; OAC 4123-6-14 ; OAC 4123-6-20 ; OAC 4123-6-37.1 ; OAC 4123-6-37.2 ; OAC 4123-6-37.3 ; OAC 4123-6-45 ; OAC 4123-6-45.1 ; OAC 4123-18-09
Effective Date:	04/01/2019
Origin:	Medical Policy
Supersedes:	N/A
History:	New
Review date:	07/01/2023

I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides guidance on the capturing of relevant information which verifies the performance of services for which a timed service code is used to bill BWC and to clarify how time for those codes is to be documented. This policy provides controlling context for previous language which addressed how timed services codes were to be documented.

II. APPLICABILITY

This policy applies to all BWC identified timed procedure codes and services used in BWC fee schedules, including CPT or HCPCS code description which reflects a unit of service that is counted in minutes or hours. (e.g. each 15 minutes; or 11-20 minutes of medical discussion). This policy is applicable to bills with dates of service on or after April 1, 2019.

III. DEFINITIONS

Timed services – nationally recognized or BWC local level procedure codes which, per their definitions are classified as time-based (or “timed”) codes and **require** a time-based factor to be met.

Timed Evaluation and Management (E&M) service - when counseling and/or coordination of care dominates (more than 50%) of an injured worker E&M service encounter.

Timed service for vocational rehabilitation – BWC local level vocational rehabilitation procedure code which has a unit of service of 6 minutes or greater.

Non-timed services – nationally recognized or BWC local level procedure codes with definitions that include **typical** time spent on the service are not considered timed services for the purposes of this policy.

Total treatment time – time the injured worker spent in the session or encounter with the provider. Also known as total session time.

IV. POLICY

- A. When a provider performs a single timed procedure in a treatment session and no other services, documentation shall include the start and stop time of the service.

- B. When a provider performs two or more procedures in a treatment session (timed or untimed), documentation for the timed service shall include:
 - 1. Total treatment time (i.e. total session time), documented as start and stop times, and;
 - 2. Total accumulated time for all timed services, documented in number of minutes; and
 - 3. Total time for each individual timed procedure, documented in number of minutes.
 - 4. Example:
 - Total treatment/session time from 12 noon to 1pm;
 - Total time for all timed services: 30 minutes;
 - By procedure code:
 - 10 minutes gait training;
 - 20 minutes manual therapy.

- C. When a provider chooses to bill an E&M service as a timed service,
 - 1. The extent of counseling and/or coordination of care must be documented in the medical record, including:
 - a. The minutes spent in face-to-face counseling or coordinating care; and
 - b. A description of the counseling and/or activities to coordinate care; and
 - 2. Documentation requirements IV. A, B and E also apply.

- D. For timed service codes on the vocational rehabilitation fee schedule, the following documentation requirements apply only when the provider is performing in-person (i.e. face-to-face) services:
 - 1. When billing for travel, the documentation shall be reported as the start and stop time of the **meeting** associated with the travel; or
 - 2. When billing for all other timed vocational rehabilitation services, documentation shall follow requirements in section IV.A, B and E.

- E. Time Documentation Requirements for all timed services – Required documentation shall:
 - 1. Be legibly noted in the medical record (e.g. therapy notes, psychological treatment summaries, etc.); and
 - 2. Be system generated (e.g. minutes calculated by EMR software); or
 - 3. Notated in free text fields recorded by the provider or in handwritten notes; and
 - 4. Not be routinely noted on medical bills.

Policy Name:	HOSPITAL SERVICES
Policy #:	BRM-23
Code/Rule Reference:	OAC 4123-6-01, OAC 4123-6-02.2, OAC 4123-6-04.4, OAC 4123-6-07, OAC 4123-6-10, OAC 4123-6-37, OAC 4123-6-37.1, OAC 4123-6-37.2
Effective Date:	04/01/2019
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding hospital services that predate the effective date of this policy.
History:	Revised 10/1/2017
Review date:	04/01/2024

I. POLICY PURPOSE: GENERAL OVERVIEW

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the billing of hospital services for Ohio's injured workers.

II. APPLICABILITY

This policy applies to all actions relevant to the request, approval and reimbursement of hospital services within the Ohio Workers' Compensation System.

III. DEFINITIONS

Emergency – Refer to OAC 4123-6-01 for definition.

Hospital – Refer to OAC 4123-6-01 for definition.

Inpatient – Refer to OAC 4123-6-01 for definition.

Interim bill- is an incremental bill submitted by a hospital for a portion of an injured worker's confinement or course of treatment when the injured worker is expected to remain in the hospital for an extended period of time.

Late charges – Charges for services associated with, but not submitted on the original bill.

Outpatient – Refer to OAC 4123-6-01 for definition.

IV. POLICY

- A. Pursuant to rule 4123-6-37, the hospital shall notify BWC, the injured worker's MCO, QHP or self-insuring employer of an emergency inpatient admission within one business day of the hospital obtaining knowledge that the admission is related to a work-related injury.

BWC's Provider Billing and Reimbursement Manual

1. Notification shall include, at a minimum, the following data elements:
 - a. Injured worker full name;
 - b. Injured worker claim number, if available;
 - c. Date of emergency admission;
 - d. Date of notification;
 - e. Hospital name;
 - f. Hospital contact name and title; and
 - g. Hospital contact telephone number.
 2. Notification shall be in the form of an email, facsimile or a person-to-person telephone conversation. Voice messages do not satisfy the notification requirement.
- B. When the emergency department is being utilized to deliver non-emergency care per rule 4123-6-37, the injured worker, the hospital and provider of record will receive written notification that continued use of the emergency room for non-emergent services will not be reimbursed.
- C. Documentation Requirements – Hospitals shall submit documentation to support billed services. Documentation may include (as applicable):
1. Emergency department report;
 2. Admission history and physical;
 3. Operative report;
 4. Discharge summary and/or progress notes if admission was forty-eight (48) hours or longer in duration;
 5. Consultations;
 6. Clinical summaries;
 7. Additional documentation may be requested, including but not limited to itemized billing statements, laboratory, radiology and other diagnostic reports.
- D. General Billing Requirements
1. Hospital bills shall be submitted on the UB-04 form (i.e. CMS-1450).
 2. The UB-04 form shall be completed in accordance with the National Uniform Billing Committee (NUBC) specifications, except as otherwise noted in the appendix of this policy.
 3. Hospitals may submit bills hard copy or via electronic transmission unless otherwise noted in this policy.
- E. Inpatient Billing Requirements
1. The following type of bill codes are accepted for inpatient services:
 - a. 0111 – Admit through discharge bill
 - b. 0112 – Interim – first bill (not valid for provider type 34)
 - c. 0113 – Interim – continuing bill (not valid for provider type 34)
 - d. 0114 – Interim – last bill (not valid for provider type 34)
 - e. 0115 – Late charges only bill (hard copy UB-04 required; processed as adjustment to original bill)
 - f. 0117 – Replacement of prior claim (hard copy UB-04 required; processed as adjustment to original bill)

- g. 0118 – Void/cancel of prior claim (hard copy only processed as adjustment to original bill)

2. Interim Billing

- a. BWC accepts interim bills for inpatient services from drug/detoxification hospitals (provider type 35), psychiatric hospitals (provider type 36) and rehabilitation hospitals (provider type 37).
- b. BWC does not accept interim bills from acute care hospitals (provider type 34).
- c. A bill for inpatient services qualifies for interim payment on the thirtieth day of a consecutive inpatient stay and at thirty-day intervals thereafter or at the discharge date, whichever is later.
- d. The first interim bill (type of bill 0112 – Interim – first bill) shall be submitted by the hospital for the services performed from the admission date through the billing date.
- e. Additional interim bills (type of bill 0113 - Interim – continuing bill) shall be submitted by the hospital for the services performed from the day following the last billed date through the billing date.
- f. The final interim bill (type of bill 0114 – Interim – last bill) shall be submitted after the injured worker has been discharged, and shall cover the last billed date through the discharge date.

F. Outpatient Billing Requirements

- 1. The following type of bill codes are accepted for outpatient services:
 - a. 0131 – Admit through discharge bill
 - b. 0132 – Interim – first bill
 - c. 0133 – Interim – continuing bill
 - d. 0134 – Interim – last bill
 - e. 0135 – Late charges only bill (hard copy UB-04 required; processed as adjustment to original bill)
 - f. 0137 – Replacement of prior claim (hard copy UB-04 required; processed as adjustment to original bill)
 - g. 0138 – Void/cancel of prior claim (hard copy UB-04 required; processed as adjustment to original bill)
- 2. To facilitate accurate calculation of reimbursement in the outpatient prospective payment methodology, hospitals shall submit all outpatient charges for one date of service or encounter on the same bill.
- 3. Lines submitted on outpatient bills with a charge of \$0.00 are accepted and shall be priced according to the hospital outpatient reimbursement rule.

G. Non-Covered Services

- 1. The following services shall not be billed by or reimbursed to a facility billing as a hospital:
 - a. Adult day care
 - b. Assisted living
 - c. Skilled nursing facility units
 - d. Skilled nursing facility swing beds
 - e. Professional provider services

- f. BWC requires providers of the aforementioned service providers to enroll under the appropriate provider type and follow billing guidelines for those provider types as set forth in BWC's Provider Billing and Reimbursement Manual and related policies.
- 3. Treatment of unrelated illness or injury during an inpatient or outpatient encounter shall not be reimbursed.
 - a. When 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 unrelated conditions.
 - b. Hospital may be required to remove unrelated charges from the bill when reimbursement is affected.
- 4. Convenience items and services
 - a. Television, telephones, cosmetics, toiletries or other convenience items or goods requested by the injured worker solely for convenience are not reimbursable;
 - b. Basic personal services such as shaves, haircuts, shampoos which injured workers need for hygienic purposes and cannot perform themselves may be viewed as covered patient care when:
 - i. Furnished during a long-term inpatient stay;
 - ii. Included in the flat rate charge;
 - iii. Routinely furnished without charge to patients.
 - c. The injured worker may be billed for convenience items if they requested it with knowledge that they will be charged.
- 5. Private rooms
 - a. Private rooms are not covered except when the physician documents medical necessity due to one or both of the following:
 - a. The injured worker's recovery would be jeopardized without a private room;
 - b. The injured worker's condition may adversely affect other patients.
 - b. An injured worker who requests a private room because of convenience or comfort may be billed the difference between the private and semi-private room rates.
 - c. An injured worker who is provided with a private room because of the unavailability of a semi-private room shall not be billed the difference between the private and semi-private room rates.

H. Prospective, Concurrent and Retrospective Reviews

- 1. Hospital facilities are subject to prospective, concurrent and retrospective audits of bills and related documentation.
- 2. Reviews may include but are not limited to the following:
 - a. Ensure services are medically necessary for treatment of the allowed conditions;
 - b. Ensure services are related to the allowed conditions;
 - c. Ensure correct coding;
 - d. Identification of billing errors;
 - e. Identification of reimbursement errors.

BWC's Provider Billing and Reimbursement Manual

Appendix

The following table contains BWC-specific instructions for the UB-04 form (i.e. CMS-1450):

Field	Field Title	Instructions
4	Type of bill	Enter the appropriate type of bill code from sections E.1. and F.1. of this policy. No other types of bill codes are accepted.
5	Statement covers period	Surgery dates and related operating room charges must be within the date span listed in the "statement covers" period. For outpatient bills, the first and last line item service dates entered in item field 45 (service/assessment date) must be equivalent to the first and last dates in the statement covers period.
43	Revenue description	No entry required
57	Other (billing) provider identifier	If the hospital's National Provider Identifier is not unique to the hospital location, entering the hospital's 11-digit BWC provider number in this field will expedite processing. The dash in the provider number should not be included. Enter the provider number in the following format: 999999999999
62	Insured's group number	Enter the injured worker's BWC claim number.

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BWC's Provider Billing and Reimbursement Manual

Policy Name:	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS) & NEURO-MUSCULAR ELECTRICAL NERVE STIMULATORS (NMES)
Policy #:	BRM-24
Code/Rule Reference:	ORC 4752.02 ; OAC 4123-6-08 ; OAC 4123-6-16.2 ; OAC 4123-6-43 ; OAC 4123-6-45.1
Effective Date:	7/1/19
Origin:	Medical Policy
Supersedes:	All medical policies, directives and memos regarding TENS and NMES services that predate the effective date of this policy.
History:	New 2/12/97; 3/1/04; 2/1/10; 12/6/10; 11/13/15; Rev. 9/1/16
Review date:	07/01/2024

I. POLICY PURPOSE

The purpose of this policy is to ensure that the Bureau of Workers' Compensation (BWC) provides direction for the requirements for authorization, education, and documentation to accurately provide, bill and be reimbursed for TENS and NMES services provided to Ohio's injured workers. The policy clarifies requirements in the rule and emphasizes provider billing and reimbursement requirements.

Historically there has been some confusion on the billing of supplies. This policy clarifies what types of supplies can be billed and how they are to be billed.

This policy is an integration of past policy alerts and communications to provide easy access to policy information for providers.

II. APPLICABILITY

This policy is in direct support of [OAC 4123-6-43](#) and applies to all actions relevant to the request, approval and reimbursement of TENS and NMES services within the Ohio Workers' Compensation System.

III. DEFINITIONS

Transcutaneous Electrical Nerve Stimulator (TENS): A device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the injured worker's perception of pain by inhibiting the afferent pain nerve impulses and/or stimulating the release of endorphins. TENS units specifically target nerves.

Neuro-Muscular Electrical Stimulator (NMES): A device that transmits an electrical stimulus to muscle groups and causes the muscle to contract. NMES units target muscles, not nerves.

TENS Supply Kit: An all-inclusive package of supplies that must include a certain combination of supplies and supply quantities as defined by BWC, which are not separately billable. The supply kit requirements may differ based on the number of units authorized.

DME Provider: the provider that furnishes the injured worker with the unit and holds a current, valid license or certificate of registration from the State of Ohio Board of Pharmacy to sell or rent home medical equipment.

IV. POLICY

A. Provider Criteria: BWC adheres to the requirements outlined in [ORC 4752.02](#), including exemptions.

B. Authorization Requirements:

1. Authorization criteria outlined in [OAC 4123-6-43](#) must be met;
2. The device must produce constant current;
3. For authorization of either the rental period, the purchase of a TENS device, or the continued use of a TENS device, the following documentation must be submitted by the physician:
 - a. Frequency and duration of use of TENS;
 - b. Describe any limitations of use;
 - c. Substantiate continued effectiveness, including but not limited to:
 - i. Impact to the injured worker's quality of life and daily activities; and
 - ii. Short and long-term goals;
 - iii. Impact on pain modulation, levels and function with use of TENS unit must be reported using at least one of the following tools:
 - a) Visual analog scale;
 - b) Pain diagram; or
 - c) Oswestry low back questionnaire; and
 - d. Detail supply requirements:
 - i. Must be consistent with prescribed frequency and duration.
 - ii. Must explain any variation from TENS supply kit.

C. Education Requirements

1. TENS and NMES units supplied by a POR or treating provider shall be personally fitted and face-to-face instruction provided when the unit is supplied; or
2. TENS and NMES units must be personally fitted and face-to-face instruction given by a direct employee of the DME provider within five (5) business days of the request of the unit, at no additional charge unless:
 - a. The DME provider verifies and documents that the ordering POR or treating provider is supplying the instruction/education; and
 - b. Documentation must support who is performing the training.
3. Verification of the educational training must be maintained by the DME provider in accordance with [OAC 4123-6-45.1](#).
4. This verification documentation must be provided to BWC or the MCO upon request.

D. Supply Requirements

1. MCOs will authorize the delivery of supplies:
 - a. Periodically as determined by the MCO;
 - b. Quantity is based on the standard expected use of the authorized TENS unit unless the POR or treating provider provides documentation for increased utilization or exceptional needs.

- c. After the MCO approval is received for that delivery, the supplies can be delivered.
 - d. Supplies shall not be reimbursed if written authorization is not received for the supplies delivered to the injured worker.
2. TENS supply kit items include:
- a. Reusable Electrodes, unless medical necessity is documented by the POR or treating physician for required use of disposable electrodes;
 - b. Tape or another adhesive, as applicable;
 - c. Skin preparation material, as applicable;
 - i. Adhesive remover;
 - ii. Alcohol prep pads;
 - iii. Conductive paste or gel.
 - d. Battery charger (if rechargeable batteries are used)
3. The following minimum quantities apply to TENS supply kit units of service:
- a. One unit must include at a minimum: Two (2) packages of electrodes, four (4) electrodes per package;
 - b. Two (2) units must include at a minimum:
 - i. Four (4) packages of electrodes, four (4) electrodes per packages, and
 - ii. 30 alcohol prep pads, or
 - iii. Other skin preparation materials.
4. Unit maximums differ for a two-lead or a four-lead TENS unit as differentiated in the BWC fee schedule.
5. The following supplies can be billed separately:
- a. Additional/new lead wires (one unit of lead wires once every six (6) months may be billed only when there is a substantiated need for new lead wires.)
 - b. One unit of batteries equals either:
 - i. One 9-volt battery; or
 - ii. Two (2) AA batteries.
 - iii. Requests for additional units exceeding the maximum limit must have supporting documentation.
 - c. Conductive garments are rarely medically necessary but can be reimbursed when:
 - i. The injured worker cannot manage without the conductive garment because there is a such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes and lead wires; or
 - ii. The injured worker cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes and lead wires; or
 - iii. The injured worker has a documented medical condition such as skin problems that preclude the application of conventional electrodes and lead wires; or
 - iv. The injured worker requires electrical stimulation beneath a cast to treat chronic intractable pain.

E. Coding and Reimbursement of TENS/NMES

- 1. Fees for TENS and NMES units include fitting and instruction. Please refer to the most current medical and [Professional Provider Fee Schedule](#) for reimbursement rates.
- 2. BWC shall not separately reimburse for a TENS/NMES fitting and instruction.
- 3. All rental payments for the TENS unit shall be applied to the purchase price.

4. The TENS provider's bill must indicate the actual date of service, reflecting the date that the services or supplies were provided to the injured worker.

F. Special Coverage Criteria

1. TENS for Chronic Pain
 - a. Payment for a transcutaneous electrical nerve stimulator (i.e., TENS) is covered for the treatment of an injured worker with chronic, intractable pain who meets the following criteria:
 - i. Documentation of chronic pain that has been present for three (3) months;
 - ii. Documentation of the location of pain, duration of time the injured worker has had pain, and the presumed cause of the pain; and
 - iii. Documentation of other modalities that have been tried and failed.
 - b. Documentation shall support continued need and patient usage;
 - c. An MCO may not authorize continued use if:
 - i. Evidence does not support benefits to injured worker; or
 - ii. Evidence that the injured worker is not using the authorized TENS unit.
2. TENS for Acute Post-Operative Pain
 - a. TENS rental is limited to thirty (30) days beyond surgery.
 - b. For reimbursement beyond thirty (30) days, the physician must provide medical documentation for justification.
3. In cases where the TENS use may be contraindicated, the POR or treating provider may be required to submit medical justification and supporting documentation. These contraindications include but are not limited to:
 - a. Use in patients with a pacemaker (especially of the demand type).
 - b. Use during pregnancy, because it may induce premature labor.
 - c. Application over the carotid sinuses due to the risk of acute hypotension through a vasovagal reflex.
 - d. Application over the anterior neck, because laryngospasm due to laryngeal muscle contraction may occur.
 - e. The electrodes should not be placed in an area of sensory impairment (eg, in cases of nerve lesions, neuropathies), where the possibility of burns exists.
 - f. A TENS unit should be used cautiously in patients with a spinal cord stimulator or intrathecal pump.
4. NMES
 - a. A NEMS 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 muscle s that are at risk for atrophy from immobilization or disuse due to injury.
 - b. Prior authorization by BWC, the MCO or self-insured employer or their agents is required prior to NMES rental or purchase.
 - c. 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.
 - d. Reimbursement of NMES devices for home use for the treatment/prevention of muscle atrophy requires the following conditions be met:
 - i. The injured worker has suffered partial or completed loss of function in one (1) or more muscles because of an injury to a peripheral nerve or nerve root; and

- ii. Denervation is substantiated by electromyography confirming the nerve injury. The electromyography must demonstrate positive waves and/or fibrillation in the affected muscles.
- e. The authorization of reimbursement of NMES and functional electrical stimulation to enhance walking of injured workers with spinal cord injuries who meet all the following criteria:
 - i. Diagnosis of paraplegia of both lower limbs;
 - ii. Willingness to use the device on a long-term basis;
 - iii. High motivation, commitment, and cognitive ability to use the device for walking;
 - iv. Completion of a physical therapy training program of a minimum of thirty (30) sessions with the NMES unit over a three (3) month period;
 - v. Intact lower motor units (i.e., L1 and below) both muscle and peripheral nerve;
 - vi. Demonstration of brisk muscle contraction to NMES and sensory perception of electrical stimulations sufficient for muscle contraction;
 - vii. 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;
 - viii. Ability to transfer independently and demonstration of standing independently for at least three (3) minutes;
 - ix. Demonstration of hand and finger functions to manipulate controls;
 - x. Minimum of six (6) month post recovery spinal cord injury and restorative surgery; and
 - xi. Absence of hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis.
- f. NMES/functional electrical stimulation for walking is contraindicated for injured workers with spinal cord injuries with any of the following:
 - i. Cardiac pacemakers or cardiac defibrillators;
 - ii. Severe scoliosis or severe osteoporosis;
 - iii. Irreversible contracture;
 - iv. Autonomic dysreflexia; or
 - v. Skin disease or cancer at the area of stimulation.
 - vi. In cases where the IW has the conditions that would be contraindicated for NMES use, the POR or treating provider may be required to submit medical justification and supporting documentation.

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