

## Ohio Bureau of Workers' Compensation 2010 Professional Provider Medical Services Fee Schedule

The five character codes included in the Ohio Bureau of Workers' Compensation (BWC) 2010 Professional Provider & Medical Services Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2010 by the American Medical Association (AMA) and from The Health Care Procedure Coding System (HCPCS) National Level II Medicare codes.

CPT® is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures by physicians.

HCPCS are released by the Center for Medicare and Medicaid Services (CMS) as a listing of five character codes and descriptive terminology used for reporting supplies, materials and services by health care providers.

The Level III HCPCS codes include BWC local coded services.

The responsibility for the content of the BWC 2010 Professional Provider & Medical Services Fee Schedule is with the State of Ohio Bureau of Workers' Compensation and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the BWC 2010 Professional Provider & Medical Services Fee Schedule. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of the CPT®. Any use of CPT® outside of the BWC 2010 Professional Provider & Medical Services Fee Schedule should refer to the most recent edition of the Current Procedural Terminology® which contains the complete and most current listing of CPT® codes and descriptive terms. Applicable FARS/DFARS apply.

For the purposes of this fee schedule, services and/or supplies must be medically necessary and appropriate for the treatment of the work related injury. The following definitions apply:

<b>Non-Facility Fee</b>	The reimbursement fee for all bills with place of service codes 11 (Office), 15 (Mobile Unit), and 20 (Urgent Care Facility) for all in-state and out-of-state practitioners.
<b>Facility Fee</b>	The reimbursement fee for all bills with place of service codes other than 11 (Office), 15 (Mobile Unit), and 20 (Urgent Care Facility) for all in-state and out-of-state practitioners.
<b>By Report (BR)</b>	The procedure or service is not typically covered and will not routinely be reimbursed. Many of the –BR codes are unclassified/unspecified generic codes and are currently assigned a dollar amount of \$0.00. A report is required to be obtained by the MCO for reimbursement consideration. Authorization and payment of codes identified as -BR require an individual analysis by the MCO prior to submission. The MCO analysis shall include researching the appropriateness of the code in relation to the service or procedure and cost comparisons in order for the MCO to approve high quality, cost-effective medical care. Research information from the MCO is required to be submitted to the BWC Medical Policy with each request. After review by the MCO, the report must be imaged into the BWC claim and a request must be submitted, utilizing the sensitive data transmission policy, to the BWC Medical Policy email box Medpol@bwc.state.oh.us for an adjustment to be processed. MCOs should note that most CPT codes have an assigned Relative Value Unit which must be utilized to determine reimbursement. Fees for CPT codes that do not have an established RVU must be compared to a like service to assist in determining appropriate fees. HCPCS codes are price through multiple cost comparisons.
<b>Not Routinely Covered (NRC)</b>	The procedure or service is not covered unless application of the Miller criteria requires an exception. See: OAC 4123-6-16.2(B)(1) through (B)(3). Where coverage is required, the pricing is listed on the fee schedule.
<b>Never Covered (NC)</b>	The procedure or service is never covered.
<b>Negotiated</b>	Negotiated reimbursement rates are required for designated all-inclusive per diem codes. Additionally, the MCO may need to negotiate a fee with a provider that will not accept the Ohio BWC fee schedule. In those situations, MCOs are required to attempt fee negotiation and document the provider discussion attempts. The services/supplies must be medically necessary for treatment of the work-related injury. Cost comparisons by the MCO for equitable reimbursements rates may often be necessary.
<b>Modifier 22</b>	Unusual procedural services. Modifier 22 must include a report documenting circumstances for its use. Reimbursement is 120% of fee schedule amount
<b>Modifier 26</b>	Professional component reimbursement. Payment rates vary according to the RVU assigned to the CPT code when modified.

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<b>Modifier 50</b>	Bilateral procedure. Reimbursement is 150% of fee schedule amount.
<b>Modifier 52</b>	Reduced Services. Reimbursement is 50% of fee schedule amount.
<b>Modifier 53</b>	Discontinued procedures. Reimbursement is 50% of fee schedule amount unless justification for higher specified percentage is supported by medical records documentation submitted pursuant to By Report guidelines.
<b>Modifier 54</b>	Surgical care only. Reimbursement is 70% of fee schedule amount.
<b>Modifier 55</b>	Post operative management only. Reimbursement for all post op care is 20% of fee schedule amount. The post operative global surgical period for major surgery is 60 days.
<b>Modifier 56</b>	Pre-operative management only. Reimbursement is 10% of fee schedule amount.
<b>Modifier 62</b>	Two surgeons. Reimbursement is 62.5% of fee schedule amount to each surgeon.
<b>Modifier 80</b>	Assistant Surgeon Reimbursement is 20% of fee schedule amount.
<b>Modifier 81</b>	Minimum Assistant Surgeon Reimbursement is 10% of fee schedule amount.
<b>Modifier 82</b>	Assistant Surgeon (when qualified resident surgeon is not available). Reimbursement is 20% of fee schedule amount.
<b>Modifier RR</b>	Rental equipment component reimbursement
<b>Modifier NU</b>	New Equipment
<b>Modifier TC</b>	Technical component reimbursement. Payment rates vary according to the RVU assigned to the CPT code when modified.

### Conversion Factors

The following dollar conversion factors, unique to BWC, will be applied to HCPCS level I CPT© coded services:

Service type	CPT© code range Conversion factor
Anesthesia 00100 - 01999	42.50000 per 15 minute time unit
Surgery 10021 - 69990	79.10000*
Radiology 70010 - 79999	51.00000
Pathology 80048 - 89399	125% of Medicare Fee Schedule
Physical medicine 97001 – 98943	51.00000
General medicine 90281 - 96999	51.00000
99000 - 99600	51.00000

\* Injection codes shall be reimbursed at the medicine conversion factor rate of \$51.00. The CPT© codes for immunizations, vaccinations, therapeutic injections and infusions are contained in the Medicine or Surgical sections of the manual.

\*\*CPT© codes that do not have an assigned relative value unit (RVU) will be reimbursed based on historical and third party payer data.

**Note:** The total RVU adjustor for each CPT© code in BWC's payment system is carried out to five decimal places. BWC's maximum allowable rate may differ slightly from the amount listed in its fee schedule publications because BWC rounds the final product to two decimal places. This applies most frequently in cases where multiple units are billed.