

Provider Update

Billing and Reimbursement



New fee schedules

New fee schedules for 2009 are effective. The new fee schedules cover inpatient services, professional fees and ambulatory surgery centers. This year, we adopted the 2009 Inpatient Prospective Payment System (IPPS). Medicare publishes the IPPS in the *Federal Register*. These fees became effective Feb. 1, 2009. The fee schedule for professional fees became effective Feb. 19, 2009. In addition, the Ambulatory Surgery Center (ASC) Rule became effective April 1, 2009. We adopted the Medicare ASC rate schedule as finalized under the ASC Prospective Payment System (PPS). We will display the reimbursement rates by the *Current Procedural Terminology*, edition 2009/*Health Care Procedure Coding System* (CPT/HCPCS) codes. The CPT/HCPCS replaces the nine-level system we now use.

Inpatient services

- The BWC effective period is Feb. 1, 2009.
- Diagnosis related group bills
 - 120 percent of Medicare IPPS rate (previously 115 percent)
- Outlier bills
 - 175 percent of Medicare IPPS rate (previously a BWC customized formula)
 - Two-tiered payment adjustment factor system
- Direct graduate medical education (DGME)
 - 120 percent of Medicare DGME per diem (Effective Feb. 1, 2009)
- Cost-to-charge ratios for IPPS-exempt facilities

- We will use 2007 Medicaid Cost-to-Charge Ratios.
- These are available in the Appendix of Chapter 3 in the *BWC Billing & Reimbursement Manual*.

Professional fees

The professional fee schedule is available to download or view on ohiobwc.com. The new fee schedule:

- Adjusts CPT Relative Value Unit (RVUs) to 2008 Medicare amounts;
- Changes the conversion factors to \$51 for radiology and general medicine;
- Adjusts the current HCPCS to reflect the 2008 Medicare schedule;
- Increases mileage from .31 cents to .51 cents per mile for local codes and maintains all other local fees.

Ambulatory surgery centers

- Adopts the 2009 Medicare ASC Rate Schedule as finalized under ASC PPS
- Displays rates by CPT/HCPCS code
- Discontinues the use of HCPCS Level III Z Codes
- Removes the limit on the number of procedures that you can report for a single admission
- Allows additional modifiers in the ASC setting
- Discontinues the use of BWC customized modifiers
- Allows the use of Modifier -50 for bilateral procedures
- Allows the use of Modifier -59 for distinct procedures

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Global surgery edits implemented

We acquired a clinical editing software package from Thomson Reuters Healthcare. This software ensures a consistent and well-defined process for assessing provider billing. The Thomson Healthcare clinical editing does not replace the clinical editing software used by the managed care organizations. However, it provides a second-level of review. This creates a consistent and standardized approach to screening and reimbursing providers' medical bills.

The global surgical edits are not new to us. They are in our billing manual. The policy's purpose is to attain continuity of care and follow correct coding guidelines for surgical reimbursement. We feel the physician performing the surgery is the best position to continue and/or arrange the injured worker's care. If the operating physician is performing pre-operative, intra-operative and post-operative care, we do not require a modifier. The reimbursement will be 100 percent of our fee schedule for the procedure. However, if multiple providers perform pre-operative and post-operative services, we will reimburse them according to a prorated fee schedule as noted below.

- Pre-operative: 10 percent of the surgery fee
- Intra-operative: 70 percent of the surgery fee
- Post-operative: 20 percent of the surgery fee

When global surgical care is fragmented and performed by multiple providers, correct coding guidelines require each physician use the same surgical procedure code (with the appropriate modifier) identifying the services provided.

- Providers must bill the pre-operative service with the actual date of service and Modifier -56.
- Surgeons must bill the post-operative services with the date of surgery as the date of service and Modifier-55.
- A surgeon performing **only** the surgical component must attach Modifier -54 to the surgical procedure.

Please note: Physicians involved in the care should first agree on the transfer of post-operative care from the surgeon to the physician of record. The post-operative recovery period is 10 days for minor procedures and 90 days for major procedures. We will not reimburse for evaluation and management services during the global period for the same diagnosis.

We plan to move from 90 days for major procedures to 60 days in the near future. If you disagree with the denial, you may submit an appeal with your rationale to the assigned managed care organization (MCO). MCOs have a grievance hearing procedure that allows a provider, employer or employee to grieve a disputed bill payment.

Introducing our new medical director

We are proud to introduce Robert J. Balchick, M.D., M.B.A., as our new medical director. Dr. Balchick joined BWC in September 2008. As medical director, he provides medical and executive leadership experience. This will be an asset to our medical services team and our mission to ensure a timely and safe return to work for Ohio's injured workers. Dr. Balchick holds an undergraduate degree from Ohio University, a medical degree from The Ohio State University College of Medicine. He recently earned a Master of Business Administration degree from The Ohio State University's Fisher College of Business. He is also a board certified urologist.

Introducing our new pharmacy director

We are proud to introduce John Hanna, R.Ph., M.B.A., as our new pharmacy director. He began his position in May 2009 and oversees our pharmacy benefit program. The program covers drugs prescribed to treat conditions related to an injured worker's claim. Hanna most recently served as director of pharmacy for Chillicothe's Adena Health System, which serves nine counties in south central Ohio. He holds a Bachelor of Science in pharmacy from the University of Cincinnati and a Master of Business Administration degree from Xavier University.

Introducing a new firm to manage pharmacy benefits

We selected a new pharmacy benefits manager (PBM) to fulfill the medication needs of Ohio's injured workers. SXC Health Solutions Corp. We granted SXC a three-year contract, which takes effect Nov. 1, 2009. In addition to current processes, SXC will also provide a new, state-of-the-art, Web-based prior authorization technology that will enable prescribers to obtain instant approvals to fill many pharmaceutical requests. We will include additional information regarding our new PBM in the next release of the *Billing and Reimbursement Manual*.

Provider training tools

A Web-based training tutorial now is available on demand at ohiobwc.com. You can find it under the Medical Providers section, Education/Training. We divided these training videos into seven sections. They begin with a general introduction to BWC and end with frequently asked questions. We designed these videos for the new provider or office staff members. They provide valuable information, highlight forms and assist providers in billing. Please visit The Education/Training section today and provide us your feedback. Also, suggest topics for future videos. You may e-mail us at feedback.medical@bwc.state.oh.us.

Sensitive data policy

We have implemented a new sensitive data policy. We took this step due to heightened security awareness and state law. This policy prohibits the electronic transmission of sensitive data without encryption. This means the data must be password protected. This prevents unauthorized disclosure of our sensitive information.

If you receive an electronic document from us or the managed care organization (MCO) it will be password protected. When you attempt to open the attachment, you will receive a prompt asking you for a password. We and/or the MCO will provide you with the password to access the document. Once you open a document and respond to the message, the document will remain password protected when you save the changes. You can then forward that document back to us. The password will protect the information. **Please note:** We consider sending a document via fax to a phone number secure. Therefore, it is an acceptable way to communicate sensitive data.

You can communicate sensitive data information via e-mail if you redact components. For example, an injured worker's name and claim number are sensitive data. However, you may send this information via e-mail in the "masked" format below.

Not acceptable Injured worker John Smith, BWC claim #09-123456
Acceptable (masked) Injured worker John S., Claim # 09-xxx456

Reporting fraud

To protect injured workers' benefits and keep employer premiums down, we aggressively seek to identify and prevent fraud. Our special investigations department investigates allegations of fraud committed against the state insurance fund. Many fraud cases start with tips and allegations. They come from concerned citizens, injured workers, employers and medical providers who report activity they believe may violate workers' compensation system law.

If you suspect fraud, please submit a fraud allegation form. You can find the form on ohiobwc.com. Click on the Medical Providers section, then the Section Map area. You may also call our fraud hotline at 1-800-OHIOBWC to report suspected fraud. When reporting suspected fraud, you can remain anonymous.

Provider enrollment update

Maintaining accurate demographic information is important for all parties. It is each provider's responsibility to maintain his or her provider number for demographic data accuracy. Our database can house multiple practice locations per provider. However, the database, at a minimum must have one practice, remittance and correspondence address. If we receive only a practice address, all address information defaults to that address, to which we send all payment and correspondence.

It is important that you update treating provider numbers and payment provider numbers when there are changes. We do not require individual providers to be "linked" to group numbers in our database for payment purposes. But, we request you submit practice-location information for individuals. Thus each record can accurately reflect situations where a provider is working at more than one location. If applicable, please designate the primary practice location.

Provider enrollment will not accept a Post Office Box only as a practice location. We require the actual street address for each practice location. Please be certain to include this information when updating demographic information.

If you are moving, adding locations or need to register NPI information, please send the information via fax to provider enrollment at 614-621-1333. In addition, you may call 1-800-OHIOBWC, and listen to the options to speak with a provider relations representative.

C-9 form changes

We will soon change the *Physician's Request for Medical Service or Recommendation for Additional Conditions for an Industrial Injury or Occupational Disease* (C-9). Revisions will include requesting site of service, provider rendering treatment and current procedural terminology codes. Please look for these form updates in the near future. To facilitate processing, be aware you can submit this information prior to actual form changes.

Telephone calls

We may reimburse providers for calls. We will reimburse for calls per current procedural terminology (CPT) codes 99371-99373®. These calls must be medically necessary or contribute to the injured worker's overall care. Telephone calls must have supporting documentation in the medical record and contain a brief conversation description. The physician must make the call to bill the current CPTs. You should not use the codes in addition to consultation services (99241-99255) or team conferences (99361 and 99362).

Do not submit the telephone call CPT (99371-99373) for conversations with a managed care organization or us. These calls are not to serve as a replacement for face-to-face interaction with the injured worker. We encourage the use of these codes for return- to-work planning conversations between the physician and the employer. Additional information is available in our medical documentation guidelines policy available on our Web site under Chapter One of the *Billing and Reimbursement Manual*.

Five-year rule review process

We are reviewing Ohio Administrative Code Rules. This review occurs every five years. This year, the Health Partnership Program and the Self Insured Medical Rules are part of the 2009 review. We will intermittently release draft rule updates by sections for input from external stakeholders. Stakeholders include the provider associations, the self-insured community and all other parties wishing to comment.

If you want us to notify you of these revisions and to provide feedback, please send an e-mail to msdrulefeedback@bwc.state.oh.us. Include your name and title. This format meets our sensitive data policy discussed earlier in this update. To build a list for future e-mail updates, we will retain these e-mails.

E-mail list for providers and interested parties

We are building an e-mail list of providers and interested parties to receive our quarterly *Provider Update* and other medical information electronically. To assist our efforts, we request providers send us the applicable information below to the e-mail address Provlistserv@bwc.state.oh.us, or call us at 1-800-644-6292, and option 0-3-0.

1. Provider name, title, board specialty (i.e., John Smith, M.D., board certified family practice 1999)
2. Address, phone number where you can be reached 61 - 000-0000
3. Name of group you are affiliated with, practice specialty (Smith Family Practice – family medicine office)
4. Address and phone number (if it's different than above) (614) 000-0000
5. Your email address

Policy alerts

We provide policy clarifications to managed care organizations periodically in the format of a policy alert. These alerts are available on our Web site's Medical Providers page by clicking on Services and, MCO Policy Reference Guide. Policy alerts that are available include the EOB 776 override code, global surgical package, cardiac clearance and telephone calls. Please see these

alerts for additional information on these topics and others as they become available.

Treatment by more than one physician

Bureau Rule 4123-6-27 *Treatment by more than one physician states: Medical fees shall not be approved for treatment by more than one physician for the same condition over the same period of time, except where a consultant, anesthetist, or assistant is required, or where the necessity of treatment by a specialist is clearly shown and approved in advance of treatment. The rule does not apply in cases of emergency, or where the physician of record's approved treatment plan indicates the necessity for multi-disciplinary services. The MCO, or in self-insuring employers' claims, the self-insuring employer, must approve such treatment in advance, except in emergency cases.* When multiple physicians of different specialties provide evaluation and management services to an injured worker on a single day for conditions allowed in a claim, the managed care organization will make a determination of any exception to the above stated rule. It will make the determination after reviewing the documentation to reimburse each provider for the evaluation and management service as appropriate.

Iontophoresis medication

We do not reimburse medication administered to a patient via iontophoresis in a provider's office or outpatient facility. The provider of the iontophoresis treatment may pay the pharmacy provider directly for the drug's cost he or she administers and, the provider may bundle the drug's cost with the procedural charge. The pharmacy provider may bill the drug using code J3490-unclassified drugs in addition to the provider billing for the iontophoresis procedure of any exception to the above stated rule. The managed care organization responsible for the claim will determine reimbursement eligibility based on its policy.

Drug screens

We do not reimburse for drug screens performed by employers or drug screening of injured workers performed in the emergency room at the time of the injury.

Outpatient medication prior authorization

We made a number of policy changes to the outpatient drug benefit for Ohio's injured workers. Our pharmacy and therapeutics committee, and health-care quality assurance advisory committee reviewed and approved these changes. We intend for them to ensure effective treatment and outcomes at the appropriate cost. We

will include additional information regarding these policy changes in the next release of the *Billing and Reimbursement Manual*. We list the medications impacted by these changes below.

- Lidoderm (lidocaine) – We consider it for reimbursement if post-herpetic neuralgia is an allowed condition in the claim.
- Actiq (fentanyl citrate transmucosal) – We consider it for reimbursement if malignancy is an allowed condition in the claim.
- Antimigraine Drugs (Triptans) – We institute specific quantity limitations at the drug-dosage form level. The limits are available on ohiohwc.com.
- Anti-infectives – We will require prior authorization when the date of service is greater than 180 days from the date of injury. Exceptions to this limitation include but are not limited to:
 - Catastrophically injured workers;
 - Recipients of organ transplants;
 - Claims allowed for pulmonary disease, paraplegia/spinal cord injury, neurogenic bladder, recurrent urinary tract infections or valvular heart disease.

Pharmacists may enter an intervention code when submitting a bill for a claim past 180 days from the date of injury. They may do this when the drug is clearly related to the claim (i.e., recent surgery).

Non-preferred drug list – We updated this list to include non-covered drug products with each of the drug products listed as “Not Reimbursable” being available in other dosage forms and/or strengths. The products are either preferred, or in the case of carisoprodol are available with prior authorization.

Pharmacy providers

We implemented two requirements for pharmacy providers, which we will include in the next release of the *Billing and Reimbursement Manual*. They are:

- Maintain a signature log verifying receipt by the injured worker of applicable covered services;
- Include prescriber information within bills submitted electronically to the pharmacy benefit manager for payment. The prescriber information must include the national provider identification.

Overpayment recovery policy enhancement

We finalized a new, improved provider overpayment recovery policy. The enhanced policy provides more clarity on the overpayment recovery processes. We extended the time frames for provider appeals and managed care organization referrals to us. This revised policy is effective Sept. 1, 2009. We will include the policy in the next release of the *MCO Policy Reference Guide* and the *Billing Reimbursement Manual*.

Not Reimbursable	Preferred
Zanaflex® Capsules (tizanidine)	Tizanidine 2 mg and 4 mg tablets
Amrix® ER Capsules (cyclobenzaprine)	Cyclobenzaprine 5 mg and 10mg tablets
Fexmid® Tablets (cyclobenzaprine)	Cyclobenzaprine 5 mg and 10 mg tablets
Soma® 250mg Tablets (carisoprodol)	Preferred non-carisoprodol containing SMR
Flector® Patch (diclofenac)	Preferred NSAID, including oral formulations of diclofenac