Payment Policy

Medicine

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1600 E Century Ave Ste 1
PO Box 5585
Bismarck ND 58506-5585
701-328-3800
800-777-5033
www.WorkforceSafety.com

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The five character codes included in the North Dakota Fee Schedule are obtained from the Current Procedural Terminology (CPT®), copyright 2014 by the American Medical Association (AMA). 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 performed by physicians.

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Disclaimer Language

The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI, but indicates only how the procedure or service may be paid if covered by the program. The existence of a procedure code on this list is not a guarantee that the code is covered.

For reference purposes, the sections of the North Dakota Administrative Code that regulate medical services are **92-01-02-27 through 92-01-02-46**. The NDAC can be viewed at the North Dakota Legislative Council web site: http://www.state.nd.us/lr/information/acdata/html/92-01.html

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Medical Payment Methodology

The medical fee schedule uses the procedure codes and descriptions of the American Medical Association's physicians Current Procedural Terminology (CPT®). Fees are calculated using the Resource Based Relative Values (RBRVS) RVU weights established by the Centers for Medicare & Medicaid (CMS)

The medical and hospital fee schedules contain the entire list of CPT identifying codes. The listing of CPT codes in the fee schedules is not a guarantee of payment.

WSI shall use the following conversion factor table to determine the maximum allowable fee by multiplying the conversion factor by the relative value unit established in the RBRVS.

Specialty Groups	**Conversion Factor**
Medicine	66.39
Evaluation and Management	66.39
Physical & Occupational Therapy	66.39
Radiology	66.39
Professional Radiology (only)	66.39
Pathology	66.39
Surgery	66.39

WSI will update the Medical Fee Schedule conversion factor each year based on the Medicare Economic Index (MEI) for physician services published each year in the Physician Fee Schedule final rule. Appropriate adjustments will be made for RVU weight changes (if necessary). The update to the conversion factor will be applied to the separate Anesthesia conversion factor.

Workforce Safety and Insurance

Medical Payment Parameters

Reimbursement for services will be based on the established fee schedules. The appropriate fee schedule will apply to all providers, both in state and out of state, who are providing services to injured workers whose compensability is the responsibility of the North Dakota Workers' Compensation system administered by Workforce Safety & Insurance (WSI).

1. The WSI physician fee schedule will be a true fee schedule – WSI will pay the lesser of billed charges or the fee schedule amount.

2. WSI will update the Medical Fee Schedule conversion factor each year based on the Medicare Economic Index (MEI) for physician services published each year in the Physician Fee Schedule final rule. Appropriate adjustments will be made for RVU weight changes (if necessary). The update to the conversion factor will be applied to the separate Anesthesia conversion factor.

3. WSI will adopt Medicare's published Relative Value Units (RVUs) for each year (including quarterly updates). If both "Transitioned" and "Fully Implemented" RVU amounts are published, WSI will use the "Transitioned" RVU amounts.

4. WSI will incorporate Medicare's definitions and use of "facility" and "non-facility" sites of service. Services provided in a "non-facility" setting will be paid using Medicare's non facility RVUs. Services provided in a "facility" setting will be paid using Medicare's facility RVUs.

5. When Medicare publishes annual updates to the RVU weights, WSI will incorporate any transitional weight amounts.

6. There will be no adjustments to RVU weights for Geographic Practice Cost Indices (GPCI), for the work RVU floor or for other RVU adjustments except for transitional periods applied to base RVU amounts.

7. There will be no payment reduction for mid-level practitioners (NP, PA, CNS, Nurse Midwife, Clinical Psychologist, LCSW and CRNA).

8. The WSI physician fee schedule amounts will apply to all providers, both in state and out of state.

9. For those HCPCS codes with no published RVUs, payment determinations will be made based on the Ingenix regional usual and customary charge data.

10. There will be no payment reductions for radiology services provided by Chiropractors.

11. WSI will not incorporate Medicare's payment reductions for the technical portions or professional portions of radiology services when multiple procedures in the same "radiology family" are performed on the same day.

12. WSI will not incorporate Medicare's payment reductions for multiple endoscopy procedures. Medicare's multiple surgical procedure payment reductions will apply to multiple endoscopy procedures.

13. WSI will adopt Medicare's payment reductions for the technical portion of diagnostic radiology services. The payment for the technical portion of diagnostic radiology services under the Medical Fee Schedule will be limited to the payment amount under the Hospital Outpatient Fee Schedule.

14. WSI will assign one of 4 status codes to each HCPCS code. The following status codes will be used:
    - A Active Code – Will be paid under the WSI fee schedule amount
    - B Bundled Code – Payment is bundled into the payment for other services
    - C WSI Priced Code – Payment is made under WSI negotiated amounts or U&C amounts
    - P Excluded Code – No payment is made for these codes

    The following crosswalk will be used:

RVU Table Indicator	WSI Indicator
A	A
B	B
C	C
D	P
E	A, C or P
F	P
G	A
H	P
I	A, C or P
M	P
N	A or C
P	P
R	A or C
T	A or C
X	A, C or P

15. WSI will incorporate Medicare's "global surgical" periods and global surgical payment policies. Procedures subject to either the 10 or 90 day global periods are those published by Medicare in the annual RVU table. When WSI requests a visit with a patient during a global period, that visit can be paid separately if billed with modifier 32. The services would be separately paid under the Medical Fee Schedule. The following indicators will be assigned to each HCPCS code:
    - 000 No global period
    - 010 10 day global period
    - 090 90 day global period

The following crosswalk will be used:

RVU Table Indicator	WSI Indicator
000	000
010	010
090	090
MMM	000
XXX	000
YYY	000
ZZZ	000

16. WSI will adopt Medicare's percentages for pre-operative, operative and post-operative payments and require the use of the appropriate modifiers (56 – preoperative care only, 54 – surgical care only, 55 – postoperative care only).

17. WSI will adopt Medicare's multiple procedure discounts for most procedures. The following indicators will be assigned to each HCPCS code:
    - 0 No adjustment rules applied
    - 2 Standard payment adjustment rules applied (100%, 50%, 50% ….)

    The following crosswalk will be used:

RVU Table Indicator	WSI Indicator
0	0
1	0
2	2
3	2
4	0
5	0
6	0
7	0
9	0

18. WSI will adopt Medicare's bilateral surgery payment adjustments for services billed with Modifier 50. The following indicators will be assigned to each HCPCS code:
    - 0 bilateral procedure payment adjustment does not apply
    - 1 150% bilateral procedure payment adjustment applies

    The following crosswalk will be used:

RVU Table Indicator	WSI Indicator
0	0
1	1
2	0
3	0
9	0

19. WSI will adopt Medicare's assistant at surgery payment policies. The policies will apply to both physicians (modifiers 80-82) and mid-levels (modifier AS). WSI will allow assistants at surgery for those HCPCS codes that Medicare has indicated as appropriate for assistant at surgery payments. The following indicators will be assigned to each HCPCS code:
    - 1 Assistant at surgery payments are not permitted for this procedure
    - 2 Assistant at surgery payments are permitted for this procedure

    The following crosswalk will be used:

RVU Table Indicator	WSI Indicator
0	1
1	1
2	2
9	1

20. WSI will adopt Medicare's co-surgeon payment policies. WSI will allow co-surgeon billings and payment for those HCPCS codes that Medicare has indicated as appropriate for co-surgeon payments. The following indicators will be assigned to each appropriate HCPCS code:
    - 0 Co-surgeons are not permitted for this procedure
    - 1 Co-surgeons are permitted for this procedure

    The following crosswalk will be used:

RVU Table Indicator	WSI Indicator
0	0
1	1
2	1
9	0

21. WSI will not adopt Medicare's team surgery payment policy and will not pay for services billed with Modifier 66.

22. WSI will not adopt Medicare's bundling provisions that apply to "T" status codes. These codes will continue to receive separate payment when reported with other services.

23. WSI will adopt the National Correct Coding Initiative (NCCI) edits.

24. WSI will accept all Level I and II modifiers on claim forms. Those that are not used for payment modifications will be ignored by the system.

Workforce Safety and Insurance

Modifiers

When applicable, the modifying circumstances against general guidelines should be identified by the addition of the appropriate modifier code, and are reimbursed as follows:

Anesthesia by Surgeon (47)
No reimbursement in addition to base payment

Bilateral Procedure secondary procedure (50)

100% of fee schedule (1st procedure)

50% of fee schedule (2nd procedure)

Multiple Procedures (51)
The major or primary procedure is reimbursed at 100% of fee schedule, any additional procedure is reimbursed at 50% of fee schedule

Discontinued Procedure (53)
The reimbursement rate will be 50% of the fee schedule amount

Surgical Care Only (54)
Medicare's percentage based on individually assigned weights

Postoperative Management only (55)
Medicare's percentage based on individually assigned weights

Pre-Operative Care Only (56)
Medicare's percentage based on individually assigned weights

Distint Procedural Service (59)
100% of fee schedule with the appropriate multiple procedure discounts

Assistant Surgeon (80, 82, AS)
Any Physician or non-physician assisting another physician in surgery is reimbursed at 16% of fee schedule.

Co-Surgeons (62)
Based on allowed indicator, 62.5% of fee schedule for each surgeon, if allowed

Waiver of Liability Statement on file (GA)
No reimbursement allowed. Patient will be responsible for the charges.

Workforce Safety and Insurance

WSI Specific Codes

These codes replace non-descriptive CPT codes or when a CPT did not have a code established for services. The diagram below outlines the code, the intended use for the code, and the reimbursement level for each code.

WSI Code	Code Description	Long Description	Fee Schedule Amount
W0200	Telephone call with employer	• Telephone call between health care provider and employer for issues related to work restrictions • Billable in addition to an E & M charge • Documentation in medical notes required regarding the telephone call and time spend	$59.09
W0300	WSI Case Manager Visit	• Face to face discussion with a WSI Medical Case Manager, prior to, during or after injured worker office visit • Documentation in medical notes required	$108.22
W0310	Vocational Case Managers	• Face to face discussion with a Vocational Case Manager, prior to, during or after injured worker office visit • Documentation in medical notes required	$108.22
W0400	Fluidotherapy.	• Application of a modality to one or more areas • Documentation in medical notes required outlining the body area and time	$43.22 per 15 minutes
W0410	Phonopheresis	• Application of a modality to one or more areas. • Documentation in medical notes required outlining the body area and time	$61.08 per 15 minutes
W0500	Independent Medical Examination	• Examination conducted on an injured worker at the request of WSI • Detailed report required to be submitted to WSI	100% of billed amount
W0510	Independent Medical Examination – no show	• No-show reimbursement for scheduled IME when injured worker does not present to the IME appointment	100% of billed amount

WSI Code	Code Description	Long Description	Fee Schedule Amount
W0520	Independent Medical Review	• A review of injured workers' records • Detailed report required to be submitted to WSI	100% of billed amount
W0540	Functional Capacity Evaluation	• Objective, directly observed, measurement of an injured worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by the claimant and the evaluator. A physical tolerance screening and a Blankenship's functional evaluation are functional capacity evaluations. • Detailed report required to be submitted to WSI	100% of billed amount
W0545	Functional Capacity Evaluation – no show	• No-show reimbursement for scheduled FCE when injured worker does not present to the FCE appointment	100% of billed amount
W0550	Job Site Analysis	• Report of injured worker's job duties at time of injury • Detailed report required to be submitted to WSI • Excludes JA done with the Ego inititive grant program	*100% of billed amount when approved by claims adjuster
W0555	Independent Exercise	• Exercise program designed to improve overall cardiovascular, pulmonary, and neuromuscular condition of the injured worker prior to or in conjunction with return to work; prior approval required • Detailed report required to be submitted to WSI	100% of billed amount
W0560	Permanent Partial Impairment (PPI) Evaluation	• A detailed clinical report supporting the percentage rating of injury to whole body impairment and apportionment between work and non-work related if appropriate.	100% of billed amount
W0561	PPI medical records review	• Review of medical records in PPI evaluation	100% of billed amount
W0562	PPI report	• Compose PPI report	100% of billed amount

WSI Code	Code Description	Long Description	Fee Schedule Amount
W0563	Travel-PPI	• Per mile cost of PPI evaluator traveling to PPI examination site	$.575 per mile. Established each January 1st and reimbursed at US General Services Administration rate.
W0564	PPI- Lodging	• Cost of lodging of PPI evaluator traveling to PPI examination site	$83.00 per night. Estabished each January 1st and reimbursed at US General Service Administration rate.
W0565	PPI – Meals	• Cost of meals of PPI evaluator traveling to PPI examiniation site	$35 per day. Established each January 1st and reimbursed at state rates
W0566	PPI –Facility rental	• Cost of facility rental for conducting PPI	100% of billed amount
W0567	PPI – No show	• No-show reimbursement for scheduled PPI evaluation and injured worker does not present to the PPI appointment	100% of billed amount

Workforce Safety & Insurance

Provider Remittance Advice

WSI processes medical service billings weekly. A remittance advice is sent to the provider with the reimbursement check, providing information to the provider about the service, including the patient's name, date of service, procedure billed, submitted amount, and paid amount. The remittance advice also includes reason codes or explanation of benefits (EOB) codes, to explain any reductions in payment of a service or denial of payment.

Some EOB codes allow the patient to be billed for the denied charges, or for the balance of reduced charges. These instances are identified by the statement "CONTACT CLAIMANT FOR PAYMENT". When these EOB codes occur, WSI also sends a "NOTICE OF NON-PAYMENT" EOB to the patient regarding the reduced or denied charges, to inform the patient of their responsibility for the charges.

If an EOB code does not state the patient may be contacted for payment, any reduction or denial of services is not billable to the patient, the employer, or another insurer.

Copies of remittance advices can be obtained by calling 1-800-777-5033. You can access the list of our EOB codes on our website in the library section.