Fee Schedule Guidelines

Medical Provider

WSI
North Dakota Workforce Safety & Insurance

January 2022

Notice

The five character numeric codes included in the North Dakota Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2021 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. The five character alphanumeric codes included in the North Dakota Fee Schedule are obtained from HCPCS Level II, copyright 2021 by Optum360, LLC. HCPCS Level II codes are maintained jointly by The Centers for Medicare and Medicaid Services (CMS), the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA).

The responsibility for the content of the North Dakota Fee Schedule is with WSI 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 North Dakota Fee Schedules. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, and are not part of CPT, and the AMA does not recommend their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of North Dakota Fee Schedule should refer to the most current Current Procedural Terminology, which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply. CPT is a registered trademark of the American Medical Association.

The WSI Fee Schedule is not a guarantee of payment. The fact that WSI assigns a procedure or service a HCPCS code and a payment rate does not imply coverage by WSI but indicates the maximum allowable payment for approved services. Services represented are subject to provisions of WSI including: compensability, claim payment logic, applicable medical policy, benefit limitations and exclusions, bundling logic, and licensing scope of practice limitations.

Any changes made to Pricing Methodology are subject to the North Dakota Public Hearing process. WSI reserves the right to implement changes to the Payment Parameters, Billing Requirements, and Reimbursement Procedures as needed. WSI incorporates all applicable changes into the relevant Fee Schedule Guideline at the time of implementation, and communicates these changes in Medical Providers News, available on the WSI website at www.workforcesafety.com/news/medical-providers. WSI reviews and updates all Fee Schedule rates on an annual basis, with additional updates made on a quarterly basis when applicable.

For reference purposes, the sections of the North Dakota Administrative Code (N.D.A.C.) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The complete N.D.A.C. is accessible on the North Dakota Legislative Council website: http://www.legis.nd.gov/agency-rules/north-dakota-administrative-code.

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Medical Provider Pricing Methodology

Medical Provider Pricing Methodology outlines the methods used by Workforce Safety and Insurance (WSI) to determine the final rates represented on the Medical Provider Fee Schedule. The Medical Provider Fee Schedule uses the applicable procedure codes and descriptions as defined by the Healthcare Common Procedure Coding System (HCPCS), their respective payment status indicators, and payment amounts. The following specialties are included in the Medical Provider Fee Schedule: Medicine, Evaluation and Management, Physical & Occupational Therapy, Radiology, Professional Radiology, Pathology, & Surgery. In accordance with North Dakota Administrative Code 92-01-02-29.2, any provider who renders treatment to a claimant under the jurisdiction of WSI is reimbursed according to the rates assigned in the WSI Fee Schedule. A provider may access the complete Medical Provider Fee Schedule and other resources referenced within this document by visiting the Medical Provider section of the WSI website: www.workforcesafety.com.

Status Indicators

WSI assigns one of the following status indicators to each HCPCS code within the Medical Provider Fee Schedule:

Indicator	Description	Pricing Methodology
A	Active Code	Service is payable under the applicable WSI Fee Schedule.
B	Packaged Code	Service is not separately payable. Payment is packaged into the payment for another service.
C	Custom Priced Code	Service is payable using usual and customary or WSI-negotiated rates.
D	Discontinued Code	Service is not payable. Code was discontinued effective beginning of the calendar year.
P	Excluded Code	Service is not payable under the WSI Fee Schedule.

Calculation of the Reimbursement Rate

For HCPCS codes assigned a status indicator “A”, WSI applies the following formula to determine the maximum allowable reimbursement rate:

Resource Based Relative Value Unit (RBRVU) Weights	X	Conversion Factor	=	Reimbursement Rate

For 2022, the Conversion Factor is $71.78.

Annual Updates

WSI updates the Medical Provider Fee Schedule based on the Medicare Economic Index (MEI) published each year in the Physician Fee Schedule final rule. WSI uses the “Transitioned” RVU amounts if Medicare publishes both “Transitioned” and “Fully Implemented” RVU amounts. WSI adjusts the Conversion Factor for aggregate RVU weight changes when necessary.

Limitations of the Medical Provider Fee Schedule

The payment rates listed on the Medical Provider Fee Schedule indicate the maximum allowable payment for approved services only. The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI, but indicates the maximum allowable payment for approved services. The final payment rate may be impacted by the payment parameters and billing requirements enforced by WSI. A provider is encouraged to carefully review WSI's Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unneccesary delays and denials of payment.

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Medical Provider Payment Parameters

Medical Provider Payment Parameters outline the rules for payment adopted by WSI. While WSI has adopted many of Medicare's rules for payment, WSI has developed a set of unique rules that are applied to the final payment of approved services. The complete payment parameters enforced by WSI are as follows:

Advanced Beneficiary Notice (ABN) – A provider may utilize the ABN form to notify an injured employee of the costs associated with a recommended procedure that is: statutorily excluded from coverage, statutorily limited in quantity, deemed by WSI as not medically necessary to treat the work injury. To identify a charge accompanied with a signed ABN, a provider should append modifier GA to each applicable bill line. A provider should then submit the signed ABN along with the bill and medical documentation to WSI.

Aquatic Therapy – WSI reimburses for aquatic therapy seperately from an independent exercise program only when the aquatic therapy is supervised by a physical therapist.

Authorization – Several procedures included on the Medical Provider Fee Schedule require prior authorization. A provider should refer to the Utilization Review Guide for additional information.

Chiropractic Radiology – WSI does not reduce the allowable reimbursement rate for radiology services provided by a chiropractor.

Dexa Scans – WSI does not reimburse for dexa scans.

Dry Needling – WSI does not reimburse for dry needling services.

Electrodiagnostic Studies – Electrodiagnostic studies may only be performed by electromyographers who are certified or eligible for certification by the American Board of Electrodiagnostic Medicine, American Board of Physical Medicine & Rehabilitation, or the American Board of Neurology and Psychiatry certification in the specialty of clinical neurophysiology. Nerve conduction study reports must include either laboratory reference values or literature/documentation of normal values in addition to the test values.

Neuro Matrix – WSI does not reimburse for Neuro matrix services.

Surface Electromyography (EMG) – WSI does not reimburse for surface EMG services.

Eyeglasses – WSI allows for a one-time reimbursement in full for prescription eyeglasses, which would replace the exact eye glass features damaged in a work injury. WSI reimburses for subsequent eyeglass replacements, considered medically necessary to treat a work injury to the eye(s), according to the WSI Medical Provider Fee Schedule. A provider may bill the injured employee for cosmetic upgrades, which are not medically necessary to treat the work injury.

Facility vs. Non-facility – WSI incorporates Medicare's definitions and use of "facility" and "non-facility" sites of service. WSI pays for services provided in a "non-facility" setting using Medicare's non-facility RVUs. WSI pays for a service provided in a "facility" setting using Medicare's facility RVUs.

"Lesser of" Payments" – The rates listed on the ASC Fee Schedule represent the maximum amount payable for services rendered. WSI pays the "lesser of" the billed charge or the Fee Schedule amount. This is done at the line level rather than the bill level.

Massage Therapy – WSI covers massage therapy as an active modality only when prior authorized and performed by a physical therapist, occupational therapist, or chiropractor. WSI does not cover massage therapy performed by a licensed massage therapist.

Mid-level Practitioners – WSI does not reduce the allowable reimbursement rate for mid-level practitioners (NP, PA, CNS, Nurse Midwife, Clinical Psychologist, LCSW and CRNA).

Multiple Endoscopic Services – WSI does not incorporate Medicare's payment reductions for multiple endoscopy procedures. WSI does apply Medicare's multiple surgical procedure payment reductions to multiple endoscopy procedures.

No-show Appointments – WSI does not reimburse for no-show appointments.

Physical/Occupational Therapist Assistants (PTA/OTA) – When a PTA/OTA provides more than 10% of a service, the billed charge must have modifier CQ/CO appended. WSI reimburses these charges at 85% of the Fee Schedule amount.

Pre-Payment Audit – WSI performs a prepayment audit of all medical bills and requires the submitted medical documentation support each charge. WSI may deny or reduce payment if the required documentation does not accompany the bill, or the level/type of service documented does not support the procedure code billed.

Radiology Services – WSI does not incorporate Medicare's payment reductions for radiology services when multiple procedures in the same "radiology family" are performed on the same day.

> **Professional Radiology Services** – WSI does not reimburse for the interpretation of a diagnostic image completed by both a radiologist and the treating provider. If both providers submit a charge for the interpretation of the diagnostic image, WSI pays the radiologist's charge and denies the treating provider's charge.
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> **Technical Radiology Services** – WSI adopts 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 is limited to the payment amount under the Hospital Outpatient Fee Schedule.

NCCI Edits – WSI incorporates all applicable NCCI edits.

Payment Packaging – WSI packages the payment of HCPCS codes assigned a status indicator "B" into the pricing for other related services.

RVU Weight Adjustments – WSI incorporates transitional weight amounts when Medicare publishes annual updates to the RVU weights. WSI does not adjust 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.

Team Surgery Payments – WSI does not utilize Medicare's team surgery payment policy and does not pay for services billed with Modifier 66.

Time-Based Physical Medicine and Rehabilitation Codes – WSI follows Medicare's "Rule of 8" when evaluating the billable units of time-based services.

Unpublished RVUs – For those HCPCS codes with no published RVUs, WSI makes payment based on the usual and customary data determined by WSI's fee schedule vendor, FairHealth. WSI identifies HCPCS codes priced under this methodology with status indicator "C".

WSI Specific Codes – WSI requires certain services be billed using WSI-specific codes. A provider should refer to WSI-Specific Codes for additional information.

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Medical Provider Modifiers

The following information describes the pricing methodology and payment parameters for modifiers commonly used by a medical provider:

Anesthesia by Surgeon (47) – WSI does not issue additional reimbursement beyond the base payment for anesthesia completed by a surgeon.

Assistant at Surgery Payment (80, 81, 82, AS) – WSI utilizes Medicare's assistant at surgery payments and allows billings and payment for those HCPCS codes that Medicare has indicated as appropriate for assistant at surgery payments. This applies to both a physician (modifiers 80-82) and a mid-level practitioner (modifier AS). For procedures that WSI allows for assistant at surgery payment, WSI issues payment at 16% of the fee schedule rate. WSI assigns the following indicators to each HCPCS code to designate whether assistant at surgery payments are allowed:

1 Assistant at surgery payments are not permitted for this procedure
2 Assistant at surgery payments are permitted for this procedure

Bilateral Surgery Payment (50) – WSI utilizes Medicare's bilateral surgery payment adjustments for some services when billed with Modifier 50. WSI issues payment for the primary procedure at 100% of the fee schedule rate. The secondary procedure is reimbursed at 50% of the fee schedule rate. WSI assigns the following indicators to each HCPCS code to designate whether bilateral payment adjustments are applied:

0 Bilateral procedure payment adjustment does not apply
1 Bilateral procedure payment adjustment applies

Co-Surgeon Payment (62) – WSI utilizes Medicare's co-surgeon payment policies. WSI allows co-surgeon billings and payment for those HCPCS codes that Medicare has indicated as appropriate for co-surgeon payments. For procedures that WSI allows for co-surgeon payment, WSI issues payment at 62.5% of the fee schedule rate. WSI assigns the following indicators to each HCPCS code to designate whether co-surgeon payments are allowed:

0 Co-surgeons are not permitted for this procedure
1 Co-surgeons are permitted for this procedure

Discontinued Procedures (53) – WSI issues reimbursement for discontinued procedures at 50% of the fee schedule rate.

Distinct Procedural Services (59) – WSI reimburses for distinct procedural services at 100% of fee schedule, with the appropriate multiple procedure discounts.

Global Surgical Periods – WSI incorporates 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, WSI pays that charge separately if billed with modifier 32. WSI assigns the following indicators to each HCPCS code to indicate the applicable global surgical period that applies for each HCPCS code:

000	No global period
010	10 day global period
090	90 day global period

Multiple Procedure Discounts (51) – WSI utilizes Medicare's multiple procedure discounts for most procedures. For services subject to multiple procedure discounting, WSI issues payment for the primary procedure at 100% of the fee schedule rate. WSI reimburses additional procedures at 50% of the fee schedule rate. WSI assigns the following indicators to each HCPCS code and indicate whether WSI applies a multiple procedure discount to the HCPCS code:

0	No Adjustment Rules Applied
2	Standard Payment Adjustment Rules Applied

Postoperative Management Only (55) – WSI reimburses for postoperative management only services according to Medicare's percentage.

Preoperative Management Only (56) – WSI reimburses for pre-operative management only services according to Medicare's percentage.

Surgical Care Only (54) – WSI reimburses for surgical care only services according to Medicare's percentage based on individually assigned weights.

Waiver of Liability Statement on File (GA) – WSI does not issue reimbursement for these services. The patient is responsible for the charges.

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Medical Provider Billing Requirements

Medical Provider Billing Requirements outline the rules for billing adopted by WSI. WSI returns or denies inappropriately submitted bills. WSI notifies a provider of inappropriately submitted bills via a return letter or remittance advice. A provider must correct any returned bills prior to resubmission.

Bilateral Surgical Procedures – A provider is required to bill a bilateral procedure as a single line item with the bilateral procedure modifier (50) appended to the line item.

Bill Form – A provider must submit a bill for medical services on a standard CMS 1500 form or via EDI.

Bill Form Submission – WSI offers the following options for bill submission:

Electronic Billing – A provider submitting more than 50 bills per year to WSI must send charges electronically through Carisk Intelligent Clearinghouse. This option allows for the electronic submission of professional (837p) and institutional (837i) charges along with supporting medical documentation. Contact Carisk at 888-238-4792 for additional information.

Paper Billing – A provider submitting less than 50 bills per year to WSI may send charges in red and white paper format with supporting medical documentation at the following address:

Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Coding – A medical provider is required to bill using only current and appropriate CPT and HCPCS Level II codes.

Fitness Center Services – When WSI approves an independent exercise program, a facility may bill for the fitness center services using WSI-specific code W0555 on a CMS 1500, or by submitting an invoice for the charges.

Medical Documentation – A provider must submit medical documentation to support all billed charges. WSI's Documentation Policies are available for detailed information on documentation requirements.

Medical Necessity – A provider is required to bill using the same medical necessity guidelines used for Medicare.

National Provider Identification (NPI) – WSI requires entities who are eligible for NPI to be registered with National Plan & Provider Enumeration System. When applicable, WSI requires a provider to include the NPI at both the rendering provider and billing provider levels.

Time-Based Physical Medicine and Rehabilitation Codes – A provider must bill physical medicine and rehabilitation time-based codes based on the total timed-code treatment minutes. In addition, WSI requires treatment times be documented in the medical notes for all time-based codes (e.g. electrical stimulation to lumbar area performed for 10 minutes).

Timely Filing – A provider must submit bills to WSI within 365 days of the date of service.

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WSI-Specific Codes

WSI has developed a series of WSI-specific codes, which a medical provider must use in place of HCPCS codes, when applicable. These codes replace non-descriptive CPT codes or when a CPT did not have a code established for services. The table below outlines the code, the intended use for the code, and the current reimbursement level for each code.

WSI Code	Short Description	Long Description	Fee Schedule Amount
W0200	Telephone call or visit with employer	• Call or face-to-face visit between a health care provider and employer to discuss a work related injury • Billable in addition to an E & M charge when time spent is greater than 5 minutes • Summary of discussion and documentation of time spent with employer must be present in the medical notes	$83.98
W0300	WSI Medical Case Manager visit	• Face-to-face visit between a health care provider and WSI Nurse Case Manager to discuss a work related injury • Documentation of visit must be present in the medical notes	$155.04
W0310	WSI Vocational Case Manager visit	• Face-to-face visit between a health care provider and WSI Vocational Case Manager to discuss a work related injury • Documentation of visit must be present in the medical notes	$155.04
W0400	Fluidotherapy	• Modality which utilizes a dry whirlpool to provide superficial heat and sensory stimulation to the skin • Documentation of the body area treated and time spent performing the modality must be present in medical notes	$36.61 per 15 minutes
W0410	Phonopheresis	• Modality which utilizes ultrasound for transdermal medication delivery • Documentation of the body area treated and time spent performing the modality must be present in medical notes	$35.15 per 15 minutes
W0420	Electromedical Device Education	• Instruction provided to an injured employee on the use of a prescribed electromedical device (e.g., TENS unit) • Documentation of the instruction provided must be present in the medical notes • Billable in addition to any reimbursement offered by a DME supplier	$21.53

WSI Code	Short Description	Long Description	Fee Schedule Amount
W0500	Independent Medical Evaluation (IME)	• Examination performed by a neutral third-party provider to evaluate the causation and diagnosis of an injury • Evaluation must be requested by WSI • Documentation of medical record review, exam findings, and response to WSI-posed questions must be present in the report	100% of billed amount
W0510	IME- no show	• Reimbursement for a provider's lost time when an injured employee does not present to a scheduled IME appointment	100% of billed amount
W0520	Independent Medical Review	• Medical record review performed by a neutral third-party provider to evaluate the causation and diagnosis of an injury • Review must be requested by WSI • Documentation of medical record review and response to WSI-posed questions must be present in the report	100% of billed amount
W0540	Functional Capacity Evaluation (FCE)	• Evaluation which provides objective, directly observed measurements of an injured employee's ability to perform a variety of physical tasks • Documentation of findings, physical demand capabilities, and recommendations for workday tolerances must be present in the report • Evaluation must be requested by WSI • Evaluation may only be performed by a therapist who is FCE certified	100% of billed amount
W0545	FCE- no show	• Reimbursement for a provider's lost time when an injured employee does not present to a scheduled FCE appointment	100% of billed amount
W0550	Job Site Analysis	• Analysis of an injured employee's job duties and work environment performed at the injured employee's place of employment • Documentation of findings, physical demands of work duties, and recommendations for accommodations must be present in the report • Analysis must be prior approved by WSI • Analysis may only be performed by a physical or occupational therapist	100% of billed amount
W0555	Independent Exercise	• Exercise program designed to improve the overall cardiovascular, pulmonary, and neuromuscular condition of an injured employee to foster a successful return to work • Program must be prior approved by WSI • An injured employee must submit a monthly attendance log	100% of billed amount

WSI Code	Short Description	Long Description	Fee Schedule Amount
W0560	Permanent Partial Impairment (PPI) Evaluation	• Evaluation to determine the extent of whole body impairment resulting from a work injury • Documentation of clinical exam findings, final impairment rating (to include apportionment between work and non-work related injuries), and time spent in medical record review must be present in the report • Evaluation must be in accordance with the 6th Edition of the American Medical Association (AMA) Guides • Evaluation must be requested by WSI	100% of billed amount
W0563	PPI- Travel	• Reimbursement for cost of travel incurred by a PPI evaluator traveling to an evaluation site • Established each January 1st and reimbursed per mile, in accordance with the US General Services Administration (GSA) rate	$0.58 per mile
W0564	PPI- Lodging	• Reimbursement for cost of lodging incurred by a PPI evaluator traveling to a PPI evaluation site • Established each January 1st and reimbursed in accordance with the US GSA rate for North Dakota	$86.40 per night
W0565	PPI – Meals	• Reimbursement for cost of meals incurred by a PPI evaluator traveling to PPI evaluation site • Established each January 1st and reimbursed in accordance with the US GSA rate for North Dakota	$35 per day
W0566	PPI –Facility rental	• Reimbursement for cost of facility rental required to conduct a PPI evaluation	100% of billed amount
W0567	PPI – No show	• Reimbursement for a provider's lost time when an injured employee does not present to a scheduled PPI appointment	100% of billed amount
W0600	Enhanced Behavioral Testing	• This code is reimbursable only to a provider participating in the Behavioral Testing Pilot	$62.87

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Medical Provider Reimbursement Procedures

Medical Provider Reimbursement Procedures outline how WSI communicates bill processing information and issues payment to a provider. In addition, it outlines WSI requirements for reimbursement. A provider is encouraged to follow WSI Reimbursement Procedures to prevent delays in the payment processing of medical charges submitted to WSI.

Provider Registration – Prior to reimbursement for treatment, a provider is required to register the applicable Billing NPIs with WSI by completing the Medical Provider Payee Registration form. For additional information, visit the Provider Registration section of WSI's website.

Payment Address – WSI issues payment to the Pay-to Address registered on the Medical Provider Payee Registration form, regardless of the address submitted on the bill form. To update a payment address, a provider must resubmit the registration form for each applicable Billing NPI.

Remittance Advice – WSI issues remittance advices for processed medical bills each Friday. The remittance advice includes important information about a medical charge, including: patient name, date of service, procedure billed, billed amount, paid amount, and remittance advice reason codes. A provider should refer to the How to Read the WSI Remittance Advice document for assistance with interpretation of the remittance advice. This reference includes a sample remittance advice, along with definitions for significant fields within the remittance advice. Contact customer service at 1-800-777-5033 with questions or to obtain a duplicate remittance advice.

Reason Codes – The WSI Remittance Advice Reason Codes document provides a comprehensive listing and description of the reason codes utilized by WSI. Each reason code identifies a cause for the adjudication of a medical charge and specifies whether a provider may bill a patient. When a reason code specifies a provider may bill a patient, WSI sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charge. In accordance with North Dakota Administrative Code 92-01-02-45.1, if a reason code does not state that a provider may bill a patient, the provider cannot bill the charge for the reduced or denied service to the patient, the employer, or another insurer.

Bill Status Inquiries – Bill status information is available 24/7 via myWSI. The Provider Bill Status application permits a registered user to view bill receipt status and processing details as well as export results. For access, a practice must submit a myWSI Portal Registration (M14) form for each group/billing NPI. With the availability of this resource, a provider or their TPA will not need to contact WSI via phone or email to inquire on the status of a billed charge.

Overpayments – When an overpayment occurs on a medical bill, WSI will notify the provider of the overpayment in a letter. WSI allows 30 days from the date of the letter for a provider to issue the requested refund. If a provider does not issue the refund within 30 days of the date of the letter, WSI will withhold the overpayment from future payments.

Medical Services Disputes – North Dakota Administrative Code 92-01-02-46 provides the procedures followed for managed care disputes. A provider who wishes to dispute a denial or reduction of a service charge must submit the Medical Bill Appeal (M6) form, along with supporting documentation, within 30 days of the remittance advice issue date. WSI will not address a provider dispute submitted without the M6 form.

1600 E Century Ave, Suite 1
PO Box 5585
Bismarck, ND 58506-5585
701-328-3800
800-777-5033
Fax: 701-328-3820

www.workforcesafety.com