

Fee Schedule Guidelines

Medical Provider

For use with the following code ranges: 10021-19499, 20008-31899, 32035-36870, 37140-39599, 40490-42999, 43020-54901, 55000-57800, 58100-59899, 60000-61888, 62000-663746, 64400-65930, 66020-69990, 70010-79999, 80500-89240, 90460-99607, 0019T-0374T, A4262-A4550, G0008-G9187, H0001-H2037, M0064-M0301, P2031-P9060, Q0035-Q9974, R0070-R0076, S0012-S9999, V20205-V5364, W0400-W0555



North Dakota Workforce
Safety & Insurance

Revised 7/2016

Notice

The five character numeric codes included in the North Dakota Fee Schedule are obtained from 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. The five character alphanumeric codes included in the North Dakota Fee Schedule are obtained from HCPCS Level II, copyright 2014 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 (NDAC) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The NDAC is accessible at the North Dakota Legislative Council web site: <http://www.state.nd.us/lr/information/acdata/html/92-01.html>.

Table of Contents

Medical Provider Pricing Methodology	4
Status Indicators	4
Calculation of the Reimbursement Rate	4
Limitations of the Medical Provider Fee Schedule	4
Medical Provider Payment Parameters	5
Medical Provider Modifiers	7
Medical Provider Billing Requirements	9
WSI-Specific Codes	10
Medical Provider Reimbursement Procedures	13

North Dakota Workforce Safety & Insurance

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. Providers can access the complete Fee Schedule by visiting the Medical Provider Fee Schedule section of the WSI website: <https://www.workforcesafety.com/fee-schedules>.

Status Indicators

WSI assigns one of the following four (4) status indicators to each HCPCS code within the Medical Provider Fee Schedule:

Indicator	Description	Pricing Methodology
A	Active Code	Pricing is determined under the applicable WSI Fee Schedule.
B	Bundled Code	Payment is bundled into the payment for other services.
C	Custom Priced Code	Pricing is determined using Usual & Customary or WSI negotiated amounts.
D	Discontinued Code	Codes have been discontinued, effective beginning of calendar year.
P	Excluded Code	No payment is made for these codes.

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:

$$\frac{\text{Resource Based Relative Value Unit (RBRVU) Weights}}{\text{Weights}} \times \text{Conversion Factor} = \text{Reimbursement Rate}$$

For 2016, the Conversion Factor is \$67.12.

Annual Updates

WSI updates the Medical Provider Fee Schedule based on the Medicare Economic Index (MEI) for physician services 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 makes appropriate Conversion Factor adjustments 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. Providers are encouraged to carefully review WSI’s Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unnecessary delays and denials of payment.

North Dakota Workforce Safety & Insurance

Medical Provider Payment Parameters

Medical Provider Payment Parameters outlines 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:

Aquatic Therapy- Aquatic therapy must be supervised by a physical therapist in order to be reimbursed separately from an independent exercise program.

Authorization- Several procedures included on the Medical Provider Fee Schedule require prior authorization. Providers should refer to the [Utilization Review Guide](#) for additional information.

Chiropractic Radiology- WSI does not make payment reductions for radiology services provided by Chiropractors.

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.

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 services provided in a "facility" setting using Medicare's facility RVUs.

"Lesser of" Payments- The rates presented on the Medical Provider Fee Schedule represent the maximum WSI pays for the services provided; WSI pays the "lesser of" the billed charge or the Fee Schedule amount.

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

Mid-level Practitioners- WSI does not make payment reductions 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. Medicare's multiple surgical procedure payment reductions do apply to multiple endoscopy procedures.

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

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.

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 Bundling- WSI bundles 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 determinations based on the Ingenix regional usual and customary charge data. WSI identifies HCPCS codes priced under this methodology with status indicator "P".

WSI Specific Codes- WSI requires certain services be billed using WSI-specific codes. Providers should refer to [WSI-Specific Codes](#) for additional information.

North Dakota Workforce Safety & Insurance

Medical Provider Modifiers

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

Anesthesia by Surgeon (47)- WSI does not issue any additional reimbursement in addition to 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 physicians (modifiers 80-82) and mid-levels (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 or not 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 or not 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 or not 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 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.

North Dakota Workforce Safety & Insurance

Medical Provider Billing Requirements

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

Bilateral Surgical Procedures- Providers are required to bill bilateral surgical procedures on 1 line as a single unit, appended with the bilateral procedure modifier (50).

Bill Form- Providers must submit bills 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- Providers wishing to submit bills via EDI should contact Noridian EDI Support Services at 800-967-7902 for assistance.

Paper Billing- Providers may submit bills in red and white paper format only to WSI:
Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Records- WSI does not consider payment for medical services without verification of the services rendered; therefore, providers must submit all relevant medical records to the address listed above. WSI denies medical bills received without supporting medical documentation.

Bill Status Inquiries- WSI will not process requests for bill status inquiries of large volume or repetitive requests for the status of processed medical bills. In addition, WSI requests that the provider allow two (2) months from the date of bill submission before inquiring on bill status. This allows adequate time for WSI to process the bill and for the provider to receive the remittance advice.

Coding- Medical providers are required to bill using only current and appropriate CPT and HCPCS Level II codes.

Massage Therapy- Providers of massage therapy must bill using CPT 97124 for massage therapy services.

Medical Necessity- Providers are required to bill using the same medical necessity guidelines as they use 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 providers to include the NPI at both the rendering provider and billing provider levels.

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

Timely Filing- Providers must submit bills to WSI within 365 days of the date of service.

North Dakota Workforce Safety & Insurance
WSI-Specific Codes

WSI has developed a series of WSI-specific codes which medical providers 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 diagram below outlines the code, the intended use for the code, and the current 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	\$59.74
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	\$110.08
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	\$110.08
W0400	Fluidotherapy.	Application of a modality to one or more areas Documentation in medical notes required outlining the body area and time	\$44.30 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	\$23.49 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
W0520	Independent Medical Review	A review of injured workers' records Detailed report required to be submitted to WSI	100% of billed amount

WSI Code	Code Description	Long Description	Fee Schedule 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 initiative 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
W0563	Travel-PPI	Per mile cost of PPI evaluator traveling to PPI examination site	\$.54 per mile. Established each January 1 st and reimbursed at US General Services Administration rate.

WSI Code	Code Description	Long Description	Fee Schedule Amount
W0564	PPI- Lodging	Cost of lodging of PPI evaluator traveling to PPI examination site	\$80.10 per night. Established each January 1 st and reimbursed at US General Service Administration rate.
W0565	PPI – Meals	Cost of meals of PPI evaluator traveling to PPI examination site	\$35 per day. Established each January 1 st 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

North Dakota Workforce Safety & Insurance

Medical Provider Reimbursement Procedures

Medical Provider Reimbursement Procedures outlines how WSI communicates bill processing information and issues payment to medical providers. In addition, it outlines the WSI's requirements for reimbursement. Providers are encouraged to familiarize themselves with WSI's Reimbursement Procedures to reduce repetition of bill processing information and delays in payment.

Provider Registration- Providers must register with WSI in order to receive reimbursement. Providers can register by completing and submitting a W9 form or the [Payee Registration and Substitute IRS Form W9](#).

Payment Address- WSI issues payment to the address as indicated on the applicable payment bill form. If WSI has not received a W9 or Payee Registration and Substitute IRS Form W9 with the address indicated on the bill form, WSI will not issue payment until WSI receives the W9 or Payee Registration and Substitute IRS Form.

Remittance Advice- WSI issues remittance advices for processed medical bills each week on Friday. Providers must refer to the remittance advice for bill status information. Information contained on the remittance advice includes patient name, date of service, procedure billed, submitted amount, and paid amount. The remittance advice also includes reason codes, which explain any reductions or denials of payment for a service. Providers in need of a duplicate remittance advice can request these by contacting our customer service department at 1-800-777-5033.

Reason Codes- Certain reason codes allow the provider to bill the patient for the denied charges, or for the balance of reduced charges. The [remittance advice reason codes](#) identify the cause for the determination and specifically state that the provider may bill the patient. When these reason codes occur, WSI also sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charges.

In accordance with [North Dakota Administrative Code 92-01-02-45.1](#), if a reason code does not state that a provider may bill the patient, the provider cannot bill the charges for reduced or denied services to the patient, the employer, or another insurer.

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 the 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 begin withholding the overpayment from future payments.

Medical Services Disputes- [North Dakota Administrative Code 92-01-02-46](#) provides the procedures followed for managed care disputes. Providers who wish to dispute a denial or reduction of a service charge must file the [Medical Bill Appeal \(M6\)](#) form along with supporting documentation within 30 days after the date of the remittance advice. WSI will not address a provider dispute submitted without the M6 form.



**North Dakota Workforce
Safety & Insurance**

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

WSI's UR Department
701-328-5990
1-888-777-5871
Fax: 701-328-3820