DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY

WORKERS' DISABILITY COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

Filed with the secretary of state on October 12, 2023

These rules become effective immediately after filing with the secretary of state unless adopted under section 33, 44, or 45a(9) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of state.

(By authority conferred on the workers' disability compensation agency by sections 205 and 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.205 and 418.315, section 33 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, and Executive Reorganization Order Nos. 1982-2, 1986-3, 1990-1, 1996-2, 2003-1, 2011-4, and 2019-3, MCL 18.24, 418.1, 418.2, 445.2001, 445.2011, 445.2030, and 125.1998)

R 418.10106, R 418.10107, R 418.10108, R 418.10904, R 418.10912, R 418.10913, R 418.101002, R 418.101003a, R 418.101003b, R 418.101004, and R 418.101009 of the Michigan Administrative Code are amended, as follows:

R 418.10106 Procedure codes; relative value units; other billing information.
Rule 106. (1) Upon annual promulgation of R 418.10107, the health care services division of the agency shall provide separate from these rules a manual, tables, and charts containing all of the following information on the agency's website, www.michigan.gov/leo/bureaus-agencies/wdca:

(a) All Current Procedural Terminology (CPT®) procedure codes used for billing healthcare services.

(b) Medicine, surgery, and radiology procedures and their associated relative value units.

(c) Hospital maximum payment ratios.

(d) Billing forms and instruction for completion.

(2) The procedure codes and standard billing and coding instructions for medicine, surgery, and radiology services are adopted from the most recent publication titled "Current Procedural Terminology (CPT®)," as adopted by reference in R 418.10107. However, billing and coding guidelines published in the CPT codebook do not guarantee reimbursement. A carrier shall only reimburse medical procedures for a work-related injury or illness that are reasonable and necessary and are consistent with accepted medical standards.

(3) The formula and methodology for determining the relative value units is adopted from the "Medicare RBRVS: The Physicians Guide," as adopted by reference in R 418.10107, using geographical information for this state. The geographical information, (GPCI), is a

melded average using 60% of the figures published for the city of Detroit**,** added to 40% of the figures published for the rest of this state.
(4) The maximum allowable payment for medicine, surgery, and radiology services is determined by multiplying the relative value unit assigned to the procedure by the conversion factor listed in the reimbursement section, part 10, of these rules.
(5) Procedure codes from "HCPCS 2023 Level II Professional Edition," as adopted by reference in R 418.10107, must be used to describe all of the following services:

(a) Ambulance services.

(b) Medical and surgical expendable supplies.

(c) Dental procedures.

(d) Durable medical equipment.

(e) Vision and hearing services.

(f) Home health services.

(6) Medical services are considered “by report” (BR) if a procedure code listed in “HCPCS 2023 Level II Professional Edition” or “Current Procedural Terminology (CPT®) 2023 Professional Edition,” as adopted by reference in R 418.10107, does not have an assigned value.

R 418.10107 Source documents; adoption by reference.
Rule 107. The following documents are adopted by reference in these rules and are available for distribution from the indicated sources, at the cost listed in subdivisions (a) to (h) of this rule:

(a) “Current Procedural Terminology (CPT®) 2023 Professional Edition,” published by the American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #EP054123, 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amastore.com. The list price is $134.95 at the time of adoption of these rules. Permission to use this publication is on file in the agency.

(b) "HCPCS 2023 Level II Professional Edition,” published by the American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP231523, customer service 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amastore.com. The list price is $106.95 at the time of adoption of these rules.

(c) "Medicare RBRVS 2023: The Physicians' Guide," published by The American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP059623, 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amamstore.com. The list price is $159.95 at the time of adoption of these rules.

(d) “International Classification of Diseases, ICD-10-CM 2023: The Complete Official Codebook,” American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935, item #OP201423, 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amamstore.com. The list price is $112.95 at the time of adoption of these rules.

(e) “International Classification of Diseases, ICD-10-PCS 2023: The Complete Official Codebook,” American Medical Association, P.O. Box 74008935, Chicago, Illinois 60674-8935 item #OP201123, 1-800-621-8335. The publication may be purchased through the AMA’s website at www.amastore.com. The list price is $112.95 at the time of adoption of these rules.

(f) Merative™ Micromedex® Red Book® online subscription service of Merative, which can be purchased at https://www.ibm.com/products/micromedex-red-book or from Merative, 100 Phoenix Drive, Ann Arbor, Michigan 48108, 1-800-525-9083.

(g) Medi-Span® Drug Information Database, a part of Wolters Kluwer Health, which can be purchased from http://www.wolterskluwercdi.com or 1-855-633-0577.

(h) "Official UB-04 Data Specifications Manual 2023, July 1, 2022" adopted by the National Uniform Billing Committee, © Copyright 2022 American Hospital Association. As of the time of adoption of these rules, the cost of this eBook for a single user is $170.00 and is available at www.nubc.org.

R 418.10108 Definitions; A to I.

Rule 108. As used in these rules:

(a) “Acquisition cost” means the provider’s purchase cost established by an invoice detailing the line-item cost to the provider from a manufacturer or wholesaler net of any rebates or discounts.

(b) "Act" means the worker’s disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941.

(c) "Adjust" means that a carrier or a carrier's agent reduces a healthcare provider's request for payment to the maximum fee allowed by these rules, to a provider's usual and customary charge, or, when the maximum fee is by report, to a reasonable amount. "Adjust" also means when a carrier re-codes a procedure or reduces payment as a result of professional review.

(d) "Agency" means the workers' disability compensation agency.

(e) “Ambulatory surgical center" (ASC) means an entity that operates exclusively for providing surgical services to patients not requiring hospitalization and has an agreement with the centers for Medicare and Medicaid services (CMS) to participate in Medicare.

(f) "Appropriate care" means healthcare that is suitable for a particular individual, condition, occasion, or place.

(g) “Biologics” or “biologicals” include drugs or other products that are derived from life forms. Biologics are biology-based products used to prevent, diagnose, treat, or cure disease or other conditions in humans and animals. Biologics generally include products such as vaccines, blood, blood components, allergenics, somatic cells, genes, proteins, DNA, tissues, skin substitutes, recombinant therapeutic proteins, microorganisms, antibodies, immunoglobins, and others, including, but not limited to, those that are produced using biotechnology and are made from proteins, genes, antibodies, and nucleic acids.

(h) "BR" or "by report" means that the procedure is not assigned a relative value unit or a maximum fee and requires a written description.

(i) "Carrier" means an organization that transacts the business of workers' compensation insurance in this state and that may be any of the following:

(i) A private insurer.

(ii) A self-insurer.

(iii) One of the funds in chapter 5 of the act, MCL 418.501 to 418.561.

(iv) The Christopher R. Slezak first responder presumed coverage fund.

(j) "Case" means a covered injury or illness that occurs on a specific date and is identified by the worker's name and date of injury or illness.

(k) "Case record" means the complete healthcare record that is maintained by a carrier and pertains to a covered injury or illness that occurs on a specific date.

(l) "Complete procedure" means a procedure that contains a series of steps that are not billed separately.

(m) "Covered injury or illness" means an injury or illness for which treatment is mandated by section 315 of the act, MCL 418.315.

(n) "Current Procedural Terminology (CPT®)" means a listing of descriptive terms and identifying codes and provides a uniform nationally accepted nomenclature for reporting medical services and procedures. The CPT codebook provides instructions for coding and claims processing.

(o) “Custom compound” means a customized topical medication prescribed or ordered by a duly licensed prescriber for the specific patient that is prepared in a pharmacy by a licensed pharmacist in response to a licensed practitioner’s prescription or order, by combining, mixing, or altering of ingredients, but not reconstituting, to meet the unique needs of an individual patient.

(p) "Dispute" means a disagreement between a carrier or a carrier's agent and a healthcare provider on the application of these rules.

(q) "Durable medical equipment" means specialized equipment that is designed to stand repeated use, is used to serve a medical purpose, and is appropriate for home use.

(r) "Emergency condition" means that a delay in treating a patient would lead to a significant increase in the threat to the patient's life or to a body part.

(s) "Established patient" means a patient whose medical and administrative records for a particular covered injury or illness are available to the provider.

(t) "Expendable medical supply" means a disposable article that is needed in quantity on a daily or monthly basis.

(u) "Facility" means an entity licensed by this state pursuant to the public health code, 1978 PA 368, MCL 333.1101 to 333.25211. The office of an individual practitioner is not considered a facility.

(v) "Focused review" means the evaluation of a specific healthcare service or provider to establish patterns of use and dollar expenditures.

(w) "Follow-up days" means the days of care following a surgical procedure that are included in the procedure's maximum allowable payment, but does not include care for complications. The health care services division shall provide the follow-up days for surgical procedures separate from these rules on the agency’s website, www.michigan.gov/leo/bureaus-agencies/wdca.

(x) "Free standing outpatient facility" (FSOF) means a facility, other than the office of a physician, dentist, podiatrist, or other private practice, offering a surgical procedure and related care that in the opinion of the attending physician can be safely performed without requiring overnight inpatient hospital care.

(y) "Healthcare organization" means a group of practitioners or individuals joined together to provide healthcare services and includes any of the following:

(i) Health maintenance organization.

(ii) Industrial or other clinic.

(iii) Occupational healthcare center.

(iv) Home health agency.

(v) Visiting nurse association.

(vi) Laboratory.

(vii) Medical supply company.

(viii) Community mental health board.

(z)"Healthcare review" means the review of a healthcare case or bill, or both, by a carrier, and includes technical healthcare review and professional healthcare review.

(aa) "Incidental surgery" means a surgery that is performed through the same incision, on the same day, by the same doctor of dental surgery, doctor of medicine, doctor of osteopathy, or doctor of podiatry, that is not related to diagnosis.

(bb) "Independent medical examination" means an examination and evaluation that is requested by a carrier or an employee, that is conducted by a different practitioner than the practitioner who provides care.

(cc) "Industrial medicine clinic," also referred to as an "occupational health clinic," means an organization that primarily treats injured workers. The industrial medicine clinic or occupational health clinic may be a healthcare organization or may be a clinic owned and operated by a hospital for the purposes of treating injured workers.

(dd) "Insured employer" means an employer who purchases workers' compensation insurance from an insurance company that is licensed to write insurance in this state.

R 418.10904 Procedure codes and modifiers.

Rule 904. (1) A healthcare service must be billed with procedure codes adopted from "Current Procedural Terminology (CPT®) 2023 Professional Edition" or "HCPCS 2023 Level II Professional Edition," as referenced in R 418.10107. Procedure codes from the CPT code set are not included in these rules, but are provided on the agency's website at www.michigan.gov/leo/bureaus-agencies/wdca. Refer to "Current Procedural Terminology (CPT®) 2023 Professional Edition," as referenced in R 418.10107, for standard billing instructions, except where otherwise noted in these rules. A provider billing services described with procedure codes from "HCPCS 2023 Level II Professional Edition" shall refer to the publication as adopted by reference in R 418.10107, for coding information.

(2) The following ancillary service providers shall bill codes from "HCPCS 2023 Level II Professional Edition," as adopted by reference in R 418.10107, to describe the ancillary services:

(a) Ambulance providers.

(b) Certified orthotists and prosthetists.

(c) Medical suppliers, including expendable and durable equipment.

(d) Hearing aid vendors and suppliers of prosthetic eye equipment.

(e) A home health agency.

(3) If a practitioner performs a procedure that cannot be described by 1 of the codes listed in the most recent publication entitled "Current Procedural Terminology (CPT®)" or "HCPCS Level II", as adopted in R 418.10107, the practitioner shall bill the unlisted procedure code. An unlisted procedure code must only be reimbursed when the service cannot be properly described with a listed code and the documentation supporting medical necessity includes all of the following:

(a) Description of the service.

(b) Documentation of the time, effort, and equipment necessary to provide the care.

(c) Complexity of symptoms.

(d) Pertinent physical findings.

(e) Diagnosis.

(f) Treatment plan.

(4) The provider shall add a modifier code, found in Appendix A of the CPT codebook, as adopted by reference in R 418.10107, following the correct procedure code describing unusual circumstances arising in the treatment of a covered injury or illness. When a modifier code is applied to describe a procedure, a report describing the unusual circumstances must be included with the charges submitted to the carrier.

(5) Applicable modifiers from table 10904 must be added to the procedure code to describe the type of practitioner performing the service. The required modifier codes for describing the practitioner are, as follows:

Table 10904 Modifier Codes

(a) AA: When anesthesia services are performed personally by the anesthesiologist.

(b) AD: When an anesthesiologist provides medical supervision for more than 4 qualified individuals**,** being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.

(c) AH: When a licensed psychologist bills a diagnostic service or a therapeutic service, or both.

(d) AJ: When a certified social worker bills a therapeutic service.

(e) AL: When a limited license psychologist bills a diagnostic service or a therapeutic service.

(f) CO: When occupational therapy services are furnished in whole or in part by an occupational therapy assistant.

(g) CQ: When physical therapy services are furnished in whole or in part by a physical therapy assistant.

(h) CS: When a limited licensed counselor bills for a therapeutic service.

(i) GF: When a non-physician (nurse practitioner, advanced practice nurse, or physician assistant) provides services.

(j) LC: When a licensed professional counselor performs a therapeutic service.

(k) MF: When a licensed marriage and family therapist performs a therapeutic service.

(l) ML: When a limited licensed marriage and family therapist performs a service.

(m) TC: When billing for the technical component of a radiology service.

(n) QK: When an anesthesiologist provides medical direction for not more than 4 qualified individuals**,** being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.

(o) QX: When a certified registered nurse anesthetist or certified anesthesiologist assistant performs a service under the medical direction of an anesthesiologist.

(p) QZ: When a certified registered nurse anesthetist performs anesthesia services without medical direction.

R 418.10912 Billing for prescription medications.

Rule 912. (1) Prescription drugs may be dispensed to an injured worker by either an outpatient pharmacy or a healthcare organization. These rules apply to the pharmacy dispensing the prescription drugs to an injured worker only after the pharmacy has either written or oral confirmation from the carrier that the prescriptions or supplies are covered by workers' compensation insurance.

(2) When a generic drug exists, the generic drug must be dispensed. When a generic drug does not exist, the brand name drug may be dispensed. A physician may only write a prescription for "DAW," or dispense as written, when the generic drug has been utilized and found to be ineffective or has caused adverse effects for the injured worker. A copy of the medical record documenting the medical necessity for the brand name drug must be submitted to the carrier.

(3) A bill or receipt for a prescription drug from an outpatient pharmacy, practitioner, or healthcare organization must be submitted to the carrier and include the name, address, and Social Security number of the injured worker. An outpatient pharmacy shall bill the service using the National Council for Prescription Drug Program (NCPDP) Workers' Compensation/Property & Casualty Universal Claim Form or an invoice and include either the pharmacy's NPI or NCPDP number, and the NDC of the prescription drug.

(4) A healthcare organization or physician office dispensing the prescription drug shall bill the service on the CMS 1500 claim form. Procedure code 99070 must be used to code the service and the national drug code must be used to describe the drug.

(5) If an injured worker has paid for a prescription drug for a covered work illness, then the worker may send a receipt showing payment, along with the drug information, to the carrier for reimbursement.

(6) An outpatient pharmacy or healthcare organization shall include all of the following information when submitting a bill for a prescription drug to the carrier:

(a) The brand or chemical name of the drug dispensed.

(b) The NDC number from Red Book or Medi-Span, as adopted by reference in R 418.10107.

(c) The dosage, strength, and quantity dispensed.

(d) The date the drug was dispensed.

(e) The physician prescribing the drug.

(7) A practitioner or a healthcare organization, other than an inpatient hospital, shall bill a dispense fee for each prescription drug. A provider shall only be reimbursed for 1 dispense fee for each prescription drug in a 10-day period. A dispense fee must not be billed with "OTC"s, over-the-counter drugs.

R 418.10913 Billing for durable medical equipment and supplies.

Rule 913. (1) DME and supplies must be billed using the appropriate descriptor from the HCPCS Level II codebook, as referenced in R 418.10107, for the service. If the equipment or supply is billed using an unlisted or not otherwise specified code and the charge exceeds $35.00, then the acquisition cost must be included with the bill.

(2) Initial claims for rental or purchased DME must be filed with a prescription for medical necessity, including the expected time span the equipment is required.

(3) Durable medical equipment may be billed as a rental or a purchase. If possible, the provider and carrier shall agree before dispensing the item as to whether it should be a

rental or a purchased item. With the exception of oxygen equipment, rented DME is considered purchased equipment once the monthly rental allowance exceeds the purchase price or payment of 12 months rental, whichever comes first.

(4) If the worker's medical condition changes or does not improve as expected, then the rental may be discontinued in favor of purchase.

(5) If death occurs, rental fees for equipment terminates at the end of the month and additional rental payments must not be made.

(6) The return of rented equipment is the dual responsibility of the worker and the DME supplier. The carrier is not responsible and shall not be required to reimburse for additional rental periods solely because of a delay in equipment returns.

(7) Oxygen equipment must be considered a rental as long as the equipment is medically necessary. The equipment rental allowance includes reimbursement for the oxygen contents.

(8) A bill for an expendable medical supply must include the brand name and the quantity dispensed.

(9) A bill for a miscellaneous supply, for example, a wig, shoes, or shoe modification, must be submitted on an invoice if the supplier is not listed as a healthcare professional.

R 418.101002 Conversion factors for practitioner services.

Rule 1002. (1) The agency shall determine the conversion factors for medicine, evaluation and management, physical medicine, surgery, pathology, and radiology procedures. The conversion factor is used by the agency for determining the maximum allowable payment for medical, surgical, and radiology procedures. The maximum allowable payment is determined by multiplying the appropriate conversion factor by the relative value unit assigned to a procedure. The relative value units are provided for the medicine, surgical, and radiology procedure codes separate from these rules on the agency's website, www.michigan.gov/leo/bureaus-agencies/wdca. The relative value units are updated by the agency using codes adopted from "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107. The agency shall determine the relative values by using information found in the "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107.

(2) The conversion factor for medicine, radiology, and surgical procedures is $47.66 for the year 2023 and is effective for dates of service on or after the effective date of these rules.

R 418.101003a Reimbursement for dispensed medications.

Rule 1003a. (1) Prescription medication must be reimbursed at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span, adopted by reference in R 418.10107, plus a dispense fee. All of the following apply to reimbursements:

(a) The dispense fee for a brand name drug is $3.50.

(b) The dispense fee for a generic drug is $5.50.

(c) Reimbursement for repackaged pharmaceuticals is at a maximum reimbursement of AWP minus 10% based on the original manufacturer's NDC number, as determined by Red Book or Medi-Span, adopted by reference in R 418.10107, plus a dispensing fee of $3.50 for brand name and $5.50 for generic.

(d) All pharmaceutical bills submitted for repackaged products must include the original manufacturer or distributer stock package national drug code or NDC number.

(e) When an original manufacturer's NDC number is not available in either Red Book or Medi-Span, as adopted by reference in R 418.10107, and a pharmaceutical is billed using an unlisted or not otherwise specified code, the payer shall select the most closely related NDC number to use for reimbursement of the pharmaceutical.

(2) Over-the-counter drugs (OTC's), dispensed by a provider other than a pharmacy, must be dispensed in 10-day quantities and be reimbursed at the average wholesale price, as determined by Red Book or Medi-Span, adopted by reference in R 418.10107, or $2.50, whichever is greater.

(3) All commercially manufactured topical medications that do not meet the definition of custom compound dispensed by a pharmacy or a provider, must not exceed a 30-day supply. Regardless of dispensing party, reimbursement is a maximum of the acquisition cost, plus a single dispense fee. The single dispense fee is $8.50. A provider shall only be reimbursed 1 dispense fee per topical medication in a 10-day period.

R 418.101003b Reimbursement for biologicals, durable medical equipment, and supplies. Rule 1003b. (1) The carrier shall reimburse durable medical equipment (DME), supplies, and biologicals at Medicare plus 5%. The health care services division shall provide the maximum allowable payments for DME, supplies, and biologicals separate from these rules on the agency website, www.michigan.gov/leo/bureaus-agencies/wdca. Biologicals that have NDC numbers must be billed and reimbursed under R 418.10912.

(2) Rented DME must be identified on the provider's bill by RR. Modifier NU identifies the item as purchased, new.

(3) If a DME, supply, or biological exceeding $35.00 is not listed in the fee schedule, has no maximum allowable payment (MAP) value in the fee schedule, or is billed with a not otherwise specified code, then reimbursement must be the provider's acquisition cost, plus a percent mark-up as follows, for purchased DME:

(a) Invoice cost of $35.01 to $100.00 must receive cost plus 50%.

(b) Invoice cost of $100.01 to $250.00 must receive cost plus 30%.

(c) Invoice cost of $250.01 to $700.00 must receive cost plus 25%.

(d) Invoice cost of $700.01 or higher must receive cost plus 20%.

(4) If rental DME or supplies are not listed in the fee schedule, have no MAP value in the fee schedule, or are billed with a not otherwise specified code, then reimbursement must be 1 of the following:

(a) The daily rental rate must be calculated using the provider's acquisition cost, plus 20% divided by 365.

(b) If the provider is the manufacturer of the DME, the daily rental rate must be calculated using the manufacturer's cost to produce the DME, plus 20% divided by 365.

(5) A provider's failure to provide the required acquisition cost or manufacturer's cost may result in denial of reimbursement.

(6) All items and services associated with the DME rental must be included in the daily rental rate as calculated in subrule (4) of this rule and must not be unbundled and billed separately, unless otherwise indicated in the HCPCS Level II codebook as adopted by reference in R 418.10107.

R 418.101004 Modifier code reimbursement.

Rule 1004. (1) Modifiers may be used to report that the service or procedure performed has been altered by a specific circumstance but does not change the definition of the code. This rule lists procedures for reimbursement when certain modifiers are used. A complete listing of modifiers are listed in Appendix A of "Current Procedural Terminology CPT® 2023 Professional Edition," and the "HCPCS 2023 Level II Professional Edition" as adopted by reference in R 418.10107.

(2) When modifier code -25 is added to an evaluation and management procedure code, reimbursement must only be made when the documentation provided supports the patient's condition required a significant separately identifiable evaluation and management service, other than the other service provided or beyond the usual preoperative and postoperative care.

(3) When modifier code -26, professional component, is used with a procedure, the professional component must be paid.

(4) If a surgeon uses modifier code -47 when performing a surgical procedure, anesthesia services that were provided by the surgeon and the maximum allowable payment for the anesthesia portion of the service must be calculated by multiplying the base unit of the appropriate anesthesia code by $42.00. No additional payment is allowed for time units.

(5) When modifier code -50 or -51 is used with surgical procedure codes, the services must be paid according to the following, as applicable:

(a) The primary procedure at not more than 100% of the maximum allowable payment or the billed charge, whichever is less.

(b) The secondary procedure and the remaining procedure or procedures at not more than 50% of the maximum allowable payment or the billed charge, whichever is less.

(c) When multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body must be reimbursed 100% of the maximum allowable payment or billed charge, whichever is less, and the second and remaining surgical procedure or procedures must be identified by modifier code -51 and be reimbursed at 50% of the maximum allowable payment or billed charges, whichever is less.

(d) When modifier -50 or -51 is used with a surgical procedure with a maximum allowable payment of BR, the maximum allowable payment must be 50% of the provider's usual and customary charge or 50% of the reasonable amount, whichever is less.

(6) The multiple procedure payment reduction must be applied to the technical and professional component for more than 1 radiological imaging procedure furnished to the same patient, on the same day, in the same session, by the same physician or group practice. When modifier -51 is used with specified diagnostic radiological imaging procedures, the payment for the technical component of the procedure must be reduced by 50% of the maximum allowable payment and payment for the professional component of the procedure must be reduced to 75% of the maximum allowable payment. A table of the diagnostic imaging CPT procedure codes subject to the multiple procedure payment reduction are provided by the agency in a manual separate from these rules.

(7) When modifier code -TC, technical services, is used to identify the technical component of a radiology procedure, payment must be made for the technical component only. The maximum allowable payment for the technical portion of the radiology procedure is designated on the agency's website, www.michigan.gov/leo/bureaus-agencies/wdca.

(8) When modifier -57, initial decision to perform surgery, is added to an evaluation and management procedure code, the modifier -57 must indicate that a consultant has taken over the case and the consultation code is not part of the global surgical service.

(9) When both surgeons use modifier -62 and the procedure has a maximum allowable payment, the maximum allowable payment for the procedure must be multiplied by 25%. Each surgeon is paid 50% of the maximum allowable payment multiplied by 25%, or 62.5% of the MAP. If the maximum allowable payment for the procedure is BR, the reasonable amount must be multiplied by 25% and be divided equally between the surgeons.

(10) When modifier code -80 is used with a procedure, the maximum allowable payment for the procedure must be 20% of the maximum allowable payment listed in these rules, or the billed charge, whichever is less. If a maximum payment has not been established and the procedure is BR, payment must be 20% of the reasonable payment amount paid for the primary procedure.

(11) When modifier code -81 is used with a procedure code that has a maximum allowable payment, the maximum allowable payment for the procedure must be 13% of the maximum allowable payment listed in these rules or the billed charge, whichever is less. If modifier code -81 is used with a BR procedure, the maximum allowable payment for the procedure must be 13% of the reasonable amount paid for the primary procedure.

(12) When modifier -82 is used and the assistant surgeon is a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine, or a doctor of dental surgery, the maximum level of reimbursement must be the same as modifier -80. If the assistant surgeon is a physician's assistant, the maximum level of reimbursement must be the same as modifier -81. If an individual other than a physician or a certified physician's assistant bills using modifier -82, then the charge and payment for the service is reflected in the facility fee.

(13) When modifier -GF is billed with evaluation and management or minor surgical services, the carrier shall reimburse the procedure at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less.

(14) When modifier -95 is used with procedure code 92507, 92521-92524, 97110, 97112, 97116, 97161-97168, 97530, 97535, or those listed in Appendix P of the CPT codebook, as adopted by reference in R 418.10107, excluding CPT codes 99241-99245 and 99251-99255, the telemedicine services must be reimbursed according to all of the following:

(a) The carrier shall reimburse the procedure code at the non-facility maximum allowable payment, or the billed charge, whichever is less.

(b) Supplies and costs for the telemedicine data collection, storage, or transmission must not be unbundled and reimbursed separately.

(c) Originating site facility fees must not be separately reimbursed.

(15) Modifier -CO must be appended to a procedure code if the procedure was furnished entirely by the occupational therapy assistant, or if the occupational therapy assistant (OTA) has provided a portion of a procedure, separately from the part that is furnished by the occupational therapist, exceeding 10% of the total time for the procedure code. When modifier -CO is used, the procedure code must be reimbursed at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less. Modifier -CO and the corresponding 15% reduction must not be applicable if the

occupational therapist has provided more than half of the timed procedure code without the minutes provided by the OTA.

(16) Modifier -CQ must be appended to a procedure if the procedure was furnished entirely by the physical therapy assistant, or if the physical therapy assistant (PTA) has provided a portion of a procedure, separately from the part that is furnished by the physical therapist, exceeding 10% of the total time for the procedure code. When modifier -CQ is used, the procedure code must be reimbursed at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less. Modifier -CQ and the corresponding 15% reduction must not be applicable if the physical therapist has provided more than half of the timed procedure code without the minutes provided by the PTA.

R 418.101009 Reimbursement for custom compounded topical medication.

Rule 1009. (1) Six months after the effective date of this rule, a custom compound topical medication, as defined in R418.10108, must be reimbursed only when the compound meets all of the following standards:

(a) There is no readily available commercially manufactured equivalent product.

(b) No other United States Food and Drug Administration (FDA) approved alternative drug is appropriate for the patient.

(c) The active ingredients of the compound each have an NDC number and are components of drugs approved by the FDA.

(d) The drug has not been withdrawn or removed from the market for safety reasons.

(e) The prescriber is able to demonstrate to the payer that the compound medication is clinically appropriate for the intended use.

(2) Topical compound drugs or medications must be billed using the specific amount of each component drug and its original manufacturers' NDC number included in the compound. Reimbursement must be based on a maximum reimbursement of the AWP minus 10% based on the original manufacturer's NDC number, as published by Red Book or Medi-Span, adopted by reference in R 418.10107, and pro-rated for each component amount used. Components without NDC numbers must not be reimbursed. A single dispensing fee for a compound prescription is $12.50 for a non-sterile compound. The provider shall dispense a 30-day supply per prescription.

(3) Reimbursement for a custom compounded drug is limited to a maximum of $600.00. Any charges exceeding this amount must be accompanied by the original component acquisition cost invoice pro-rated for each component amount used, for review by the carrier.