Pennsylvania Workers’ Compensation
Medical Bill Review

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Workers’ Compensation Medical Bill Review Overview

- What is workers’ compensation medical bill review???
  - Review of any medical bills (hospital, provider, ancillary, DME, pharmacy) related to a work related accident

- Compensability determined by the insurance company, third party administrator, or self insured employer

- Paper intensive process

- Potential reductions through state fee schedule, nurse audit, PPO networks, and negotiations
Workers’ Compensation Medical Bill Review Overview (continued)

• Reimbursements driven by jurisdictions, not health plans

• Reimbursement methodologies vary by state
  • Medicare based schedules (% above Medicare)
  • RBRVS based schedules
  • Cost-to-Charge Ratios
  • Usual and Customary reimbursement for states without fee schedules

• States update schedules at different intervals

• State specific rules (PT caps, multiple surgical guidelines, etc.)
  and Medicare rules apply based on each state’s guidelines
Pennsylvania Workers’ Compensation Methodology

- The Pennsylvania Workers’ Compensation borrowed the Medicare Fee Schedule in 1994, and “froze” the fees.
- Each year the fee schedule is then updated per the Average Weekly Wage (AWW) calculation is set by the Governor’s office. For 2012, the increase is 1.5%.
- The increase is effective the 1st of the year, however typically is not released to Mid January.
In-Patient Bills

• DRG’s are currently “frozen” in grouper 12 from 1 to 495 and must be cross walked by the provider.
• PA Inpatient Trauma bills reimbursed at 100%, if trauma guidelines meet.
• Rehab and Psych are not reimbursed as DRG, however are reimbursed per the Part A provider, service codes (charge master) revenue codes.
• All hospital bills must have the itemized bills and medical records in order to review.
Outpatient Hospital Bills

• Outpatient Hospital bills are reimbursed according to charge master. These codes are found on the itemized page of the hospital bills and are linked to the hospitals Medicare Number.

• Charge master codes are updated quarterly and are not applied retroactively.

• Revenue codes 250-259, 636-639 are reimbursed to the hospitals cost-to-charge ratio.

• Revenue codes 300-319 are reimbursed according to the CPT code
Outpatient Hospital Bills (continued)

- On the itemized page that units are very important. If units are not supplied, the default is one unit.
- Refer to example of outpatient hospital bill and itemization
Ambulatory Surgery Centers

- Ambulatory Surgery Centers (ASCs), provide outpatient surgical services (Regulation 127.3)
- ASCs operate as independent or under common ownership, license or control of a hospital.
- Approved by Medicare, and Licensed by the PA Dept of Health.
- Charge Master Table EF1 is needed to find the CPT code and the reimbursement group number (1-9)
- Charge Master Table F is needed to link the Medicare Provider # or NPI # for the reimbursement.
• If the ASC is not listed in Table F, the facility may not be reimbursed as an ASC.

• Regulation 1271.25 states that surgical procedures not assigned a reimbursement on the fee schedule were paid at 80% of the providers charge, however effective 01.01.2011 the state has allowed for the use of a Usual & Customary database. This document is included for your reference.

• Multiple procedure rules apply as well as bundling rules.
The following is included in an ASC billing:

- The facility charges for the OR and Recovery Room
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, equipment and intraocular lenses for insertion after cataract surgery.
- Work done by nurses, orderlies, Tech staff and “simple tests” (Urinalysis, etc)
Ambulatory Surgery Centers (continued)

- What is not included in an ASC Payment
  - Physician Services
  - DME for patients home use
  - Prosthetic devices or implants
  - Fluroscopic guidance
Trauma Guidelines

- 127.128: “Acute Care providers in a Trauma Center or a Burn Facility are exempt from the medical fee cap and shall be paid based on 100% of billed charges”

- Pertains to Part A & Part B providers

- Pertains to the full course of the hospital treatment, until the patient is either discharged home or to a rehab or skilled nursing facility

- Part B providers are not exempt from the Multiple Procedure & bundling/unbundling rules
Trauma Guidelines (continued)

- Criteria for Trauma Guidelines
  - The patient has an immediate life threatening injury or urgent injury
  - Mechanism of injury
  - Level of Consciousness
  - Types of injury
  - Co-Morbid Factors
  - Facility is a Trauma/Burn Center

All documentation must support the billing for Trauma.
Other Rules & Guidelines

- Documentation must support charges billed

- Unlisted codes such as 99070, 97139, E1399 if billed on a CMS1500, identify the code, requires explanation either next to the code on the same line or on line 19 per CMS guidelines.

- CCI & MUE Edits can be applied.

- Multiple Surgery Rules apply.

- When billing modifier 59, documentation must support additional services.
Other Rules & Guidelines

- Pennsylvania Workers’ Compensation Act does not recognize the use of Temporary Codes. These CPT codes begin with G, K, Q, S, T and Category III Codes.

- Rental rates may be reimbursed up to a maximum of 13 months or until the purchase price is met.

- Supplies, instructions & repairs are not reimbursable for rentals (RR). A common error, A4556 electrodes separately with a rented TENS unit. Electrodes are included in the rental.
Other Rules & Guidelines

• When billing for an Assistant Surgeons fees, documentation in the medical records must support the billing of these charges.

• When services are rendered by a Physician Assistant or Nurse Practitioner; the appropriate modifier must be billed.

• Services rendered by a Licensed Message Therapist (LMT) or Licensed Acupuncturist are not covered under the Act.
Questions ???