

BWC's Provider Billing and Reimbursement Manual

Title	Description
Policy Name:	General Reimbursement Guidelines
Policy Number:	BRM-2017-10
Code/Rule Reference:	OAC 4123-6 , OAC 4123-6-04.3 , OAC 4123-6-07 , OAC 4123-6-10 , OAC 4123-6-25 , ORC 4121.44(O)
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Supersedes:	
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I. **POLICY PURPOSE: GENERAL OVERVIEW**

The purpose of this policy is to define general reimbursement guidelines for all provider types. Provider type-specific information and general billing guidelines can be found in additional Health Partnership Program Ohio Administrative Code (OAC) Chapter 4123-6 rules and in other policies within the Billing and Reimbursement Manual.

II. **APPLICABILITY**

This policy applies to all actions related to the request, approval, and reimbursement of medical fees to providers within the Ohio workers' compensation system.

III. **DEFINITIONS**

Not applicable.

IV. **POLICY**

A. **Medical Coding Guidelines**

1. Diagnostic Coding Guidelines
 - a. All medical providers shall report the ICD diagnosis code(s) representing the conditions(s) being treated during the encounter.
 - i. The provider shall utilize national correct coding guidelines when reporting diagnoses, using the appropriate code from the ICD code set effective for the date of service.

- ii. Accurate diagnosis reporting is important as coding may impact the provider's reimbursement and data integrity.
 - b. The provider must bill the condition(s) treated, regardless of the ICD condition(s) allowed in the claim, however, the provider should not request that additional conditions be added to a claim solely for billing purposes.
 - c. The provider shall contact the appropriate resource if the provider has questions about whether services are related to a claim.
 - i. The MCO and the employer for state-fund claims; or
 - ii. The provider's bill processing representative for self-insured claims.
 - d. Specific information about the ICD(s) in Ohio Workers' Compensation is available on BWC's ICD reference page:
<https://www.bwc.ohio.gov/provider/services/ICDforBWC.asp>.
- 2. Procedure and Service Coding Guidelines
 - a. BWC and the MCO shall accept the following billing codes, dependent upon provider and bill types.
 - i. HCPCS Level I (CPT®) billing codes as established by the American Medical Association. HCPCS Level I codes are descriptive codes for reporting medical services and procedures.
 - ii. Anesthesia CPT® codes (00100-01999) are recognized and required.
 - iii. HCPCS Level II billing codes as established by the Centers for Medicare and Medicaid Services. HCPCS Level II codes are descriptive codes for reporting durable medical equipment, dental, vision, and other services.
 - iv. BWC local level billing codes are descriptive terms and identifying codes for services and equipment specific to Ohio workers' compensation. Local codes begin with a "W" or "Z".
 - b. The provider shall report the correct procedure or service codes based on treatment and/or services actually provided and shall utilize codes in effect for the date of treatment or service.
 - c. The provider shall utilize correct coding guidelines for treatment or service based on provider type and shall follow billing and reimbursement guidelines established by BWC and the MCO medically managing the claim.
 - d. The provider must bill the provider's usual charges for treatment and/or services reported.
 - e. Billing From All Other BWC Certified Providers - Billing from all other BWC certified providers, including, but not limited to, ambulance, durable medical equipment supplier, orthotist, prosthetist, and traumatic brain

injury facilities must be submitted to the MCO on a CMS-1500 using the appropriate HCPCS Level I (CPT®) or HCPCS Level II codes or BWC local level codes.

- f. Other Billing and Reimbursement Manual policies clarify provider or bill type specific details.
3. Valid Modifiers
- a. Effective January 1, 2015, BWC and the MCO accept all HCPCS and CPT® modifiers on medical bills. The modifiers include ambulance modifiers to allow the provider to indicate the trip's origin and destination.
 - b. BWC and the MCO shall continue to accept a small number of proprietary BWC modifiers in addition to the national standard modifiers.
 - c. Vocational Rehabilitation Modifiers (W2-W3) BWC recognizes three (3) levels of vocational rehabilitation case complexity.
 - i. Complexity Level 1 does not require a modifier and is reimbursed at one-hundred percent (100%) of the unit of service fee. Modifiers for Complexity Levels 2 and 3 and their corresponding levels of reimbursement are as follows:
 - ii. W2 Complexity Level 2 – One-hundred and three percent (103%) of unit of service fee; and
 - iii. W3 Complexity Level 3 – One-hundred- and four-point-two-percent (104.2%) of unit of service fee.
 - iv. Additional information is included in the vocational rehabilitation fee schedule at the following link: [Fee Schedules | Bureau of Workers' Compensation \(ohio.gov\)](#).
 - d. Modifiers for Reimbursement for Multiple Claims: BWC has four (4) proprietary modifiers used to allow reimbursement for physical medicine treatment in two (2) claims for the same injured worker and date of service:
 - i. PC-Primary Claim (osteopathic or chiropractic treatment)
 - ii. SC-Secondary Claim (osteopathic or chiropractic treatment)
 - iii. PT-Primary Claim (other physical medicine procedures)
 - iv. ST-Secondary Claim (other physical medicine procedures)
4. By-Report codes for Professional Services
- a. By-Report codes are codes for a procedure or service that are not typically covered and BWC shall not routinely reimburse.
 - b. No set fee is associated with the procedure or service.
 - c. The provider should give information to the MCO to allow appropriate review.

- d. Authorization and payment of By-Report codes require an individual analysis by the MCO prior to the submission of the request for approval to BWC Medical Policy.
- e. MCO analysis includes:
 - i. Researching the appropriateness of the By-Report code in relation to the service or procedure; and
 - ii. Appropriate cost comparisons.

B. Reimbursement Review & Payment

- 1. It is the MCO's responsibility to ensure services and supplies are medically necessary and related to the allowed claim conditions before approving reimbursement.
- 2. Each MCO is responsible for adjudicating all bills for claims currently assigned to that MCO. However, in the event of an MCO transition, if the former MCO receives a bill after the transition date and has sufficient information to process the bill, then the bill shall be processed by the former MCO. It is the newly assigned MCO's responsibility to contact the former MCO in cases where there is not sufficient information to process a bill.
 - a. MCO Reimbursement Review
 - i. The MCO is responsible for reviewing the medical documentation to determine if the diagnoses are accurately reported.
 - ii. If the MCO determines that the billed diagnosis code is not accurately reported, then EOB 323, *payment is denied as the diagnosis billed does not match the diagnosis code listed in the accompanying reports*, may be applied, which shall result in the denial of the bill.
 - iii. It is the provider's responsibility to correct the coding on the bill and resubmit the bill for payment consideration.
 - iv. If the MCO determines the diagnosis is accurately reported, not allowed in the claim, but related to the injured worker's work-related injuries, then an MCO may apply an override to the bill to allow for reimbursement.
 - v. The MCO is responsible for payment of medical services provided in the treatment of work-related allowed compensable conditions and shall review all bills submitted in accordance with [OAC 4123-6-04.3](#) and [OAC 4123-6-25](#).
 - b. Payment of Bill
 - i. The MCO shall submit the bill electronically to BWC within seven (7) business days of receiving a bill unless:
 - ii. The bill cannot be processed due to missing or invalid data elements; or

- iii. The bill has been previously paid or is currently in process (i.e. duplicate bill).
- iv. If the bill cannot be processed, the MCO shall return the bill to the provider noting the reason for rejection.
- v. BWC shall approve payment and electronically transfer funds to the MCO within seven (7) business days of receiving the bill from the MCO.
- vi. The MCO shall send the payment and remittance advice to the provider within seven (7) days of receiving payment from BWC.

C. Miscellaneous Billing Provisions

1. Payment does not include reimbursement for any sales tax for services and/or items provided to the injured workers, as BWC is exempt from sales tax payment as a State of Ohio government agency.
2. Only medical services provided shall be reimbursed. Unbundling or fragmenting charges, duplicating or over-itemizing coding, or engaging in any other practice for the sole purpose of inflating bills or reimbursement is strictly prohibited. Knowingly and willfully misrepresenting services provided to Ohio injured workers is strictly prohibited.
3. Reimbursement shall not be made for missed appointments.
4. The injured worker is not required to contribute a co-payment or meet any deductibles. The BWC certified provider is responsible for billing the appropriate MCO for reimbursable covered services and shall not, in accordance with the provider agreement, request payment from the injured worker.
5. Balance billing - The health-care provider must accept the reimbursement from an MCO, BWC, or the self-insuring employer as payment in full. Neither the injured worker nor the employer may be billed for any difference between the provider's charge and the amount allowed by the MCO, BWC, or the self-insuring employer. See [ORC 4121.44\(O\)](#).
6. When the provider renders services for conditions that are not covered by workers' compensation, the provider must notify the injured worker that the services are not covered by the MCO, BWC, or the self-insuring employer and that the injured worker is responsible for payment.
 - a. Services and supplies never covered are defined in [OAC 4123-6-07](#), are found in the fee schedule and flagged as never covered (NC). The injured worker must agree and understand that the services are not payable by workers' compensation.
 - b. Services and supplies provided by a BWC non-certified provider, except as indicated in [OAC 4123-6-10](#), are the sole obligation of the injured worker.

D. Additional Considerations

1. Third Party Payers - When an injured worker is eligible for public or private insurance and workers' compensation benefits, the MCO, BWC, or the self-insuring employer is the primary payer. The provider will need to bill workers' compensation benefits for services related to compensable conditions before attempting to collect from another payer.
2. Settled Claims
 - a. A claim may be settled for medical and/or indemnity benefits.
 - b. BWC will send a letter to the vocational rehabilitation case manager as applicable when a settlement is requested. The MCO shall notify the provider when the settlement is filed and finalized. The provider can contact the MCO for any questions about claims and settlement.
 - c. Once the parties agree to the settlement, the claim is placed in a "Settled Pending" status followed by a thirty (30) day hold/pending period. During the thirty (30) day hold/pending period:
 - i. All Benefits Shall Suspend - That means bills cannot be paid and adjustments cannot be processed in the BWC billing system. Instead, adjustments for payable bills for dates of service prior to the "Effective Settlement Date" shall be processed after the claim is placed in the "Final Settled" status. The "Effective Settlement Date" is the date that BWC mails the approval letter noting that the parties agreed to the settlement.
 - ii. Bills for dates of service after the "Effective Settlement Date" are the responsibility of the injured worker. Providers may not require payment up front from injured workers whose claim is not in Final Settled status.
 - iii. A [Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease \(C-9\)](#) form for a date of service on or after the "Effective Settlement Date" shall be dismissed.
 - iv. A [C-9](#) for a date of service prior to the "Effective Settlement Date" that is submitted to the MCO within one (1) year from the date of service shall be processed, per MCO contract requirement.
 - v. An appeal to MCO decisions on a [C-9](#) for a date of service prior to the "Effective Settlement Date" is subject to the Alternative Dispute Resolution process.
3. The MCO and BWC shall ensure resolution of all timely submitted bills for services rendered prior to the "Effective Settlement Date." Contact the MCO

when a timely submitted bill for services prior to the Effective Settlement Date has not been paid.