MHS22
MEDICAL & HEALTH SYMPOSIUM • APRIL 7-9

Navigating Treatment Approvals and Reimbursement

What Providers Need To Know To Get Paid

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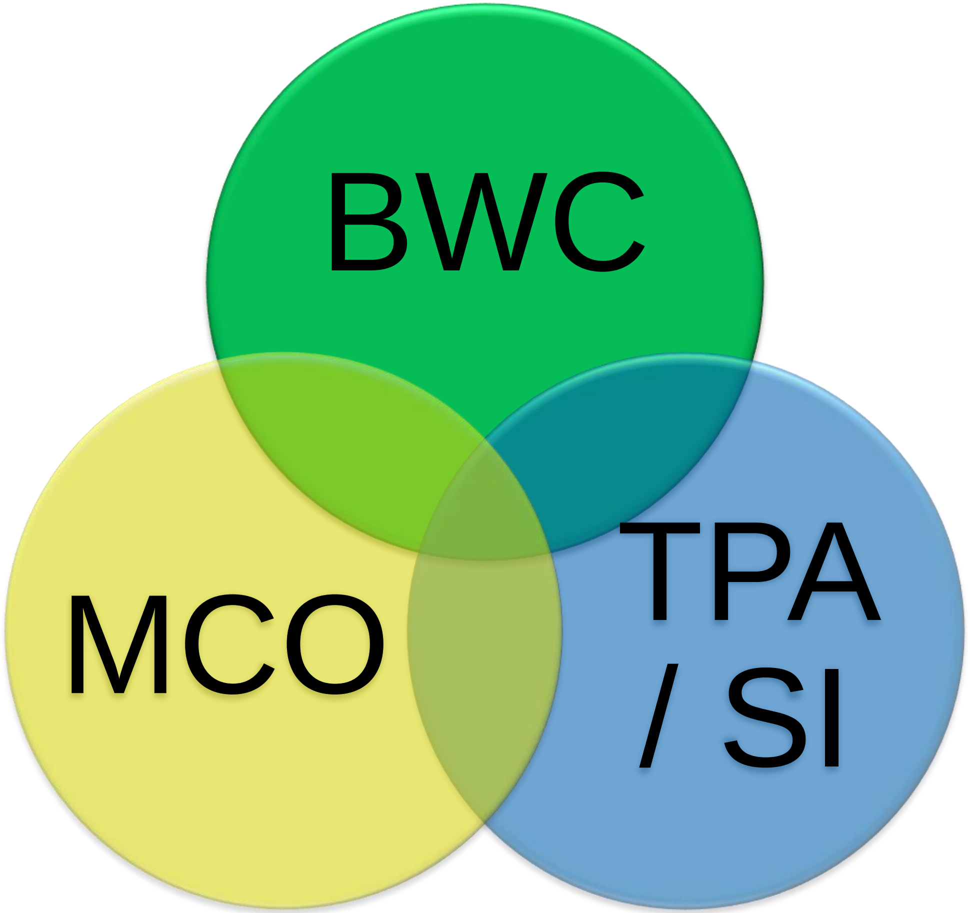
Navigating Success
Session Objectives

- Identify the various tools and materials used by BWC and the MCOs in the reimbursement process.
- Identify selected common billing mistakes that lead to a denial.
- Recognize the important data elements captured during the treatment-approval process and the impact on reimbursement.

Key Parties in the Reimbursement Process



Key Parties in the Reimbursement Process

BWC

- Establishes benefit plans
- Establishes reimbursement rates and methodologies
- Establishes billing policies
- Funds MCO provider accounts

Key Parties in the Reimbursement Process

MCOs

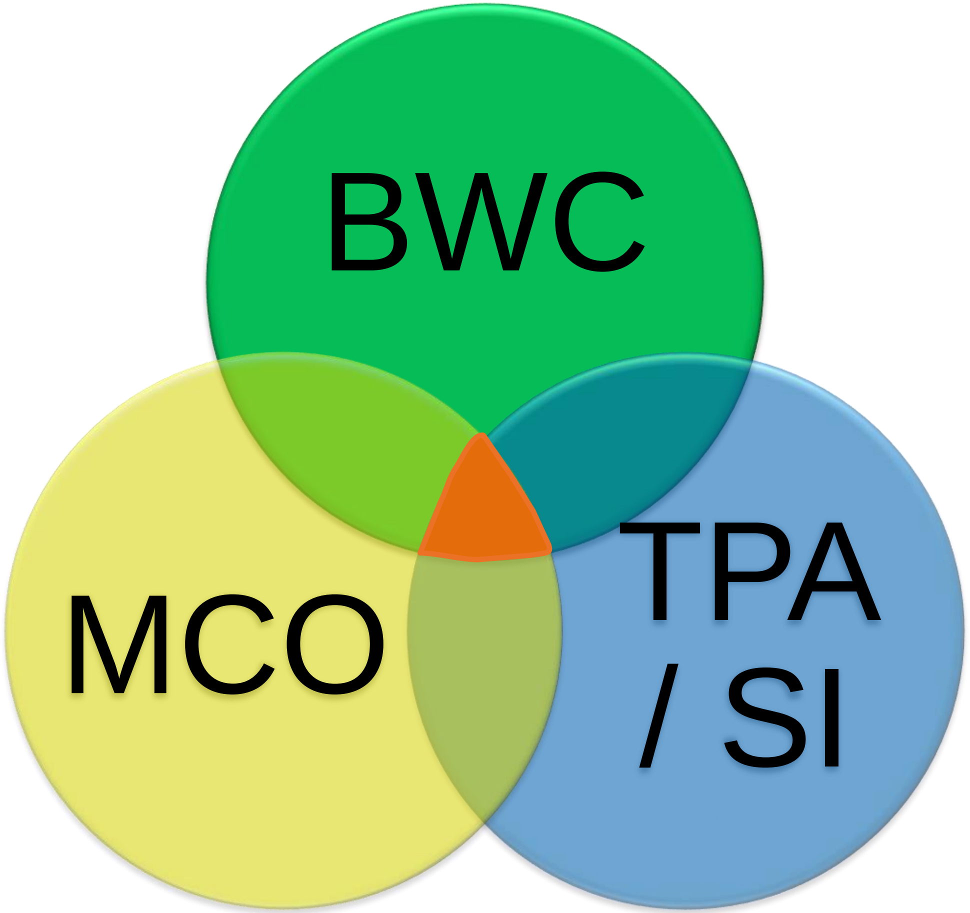
- Receives provider bills
- Process bills per:
  - Reimbursement rules and policies
  - Negotiated alternative reimbursement rates
- Directly reimburse providers

Key Parties in the Reimbursement Process

Self-Insured Employers / Third Party Administrator

- Receives provider bills
- Process bills per:
  - Relevant reimbursement rules and policies
  - Negotiated alternative reimbursement rates and/or service agreements
- Directly reimburse providers

Key Parties in the Reimbursement Process



Reimbursement Schedules

- Five individual schedules
  - Inpatient Hospital
  - Outpatient Hospital
  - Ambulatory Surgery Center (ASC)
  - Professional Provider and Medical Services
  - Vocational Rehabilitation
- Medicare’s methodologies used
- Nationally recognized coding standards

Reimbursement Guiding Principle

Ensure access to high-quality medical care

- By establishing an appropriate benefit plan and terms of service.
- With a competitive fee schedule, which enhances medical provider networks.

Right treatment

Right time

Right provider\place

Reimbursement Objectives

- Maintain stability in the environment and reimbursement methodologies.
- Ensure injured workers access to quality care.
- Promote efficiency in providing quality services.
- Maintain a competitive environment where providers can render safe and effective care.

Services have been provided, and now I want to get paid?

The Impact of Bill Review.

What is Bill Review?

- Support tools used:
  - BWC reimbursement schedules.
  - Provider Billing and Reimbursement Manual (BRM).
  - National services and billing standards.
- Utilization Review (UR) vs. Bill Review (BR)
  - UR executed at the front-end of the process.
  - BR executed at the back-end of the process.

The Treatment Authorization Request

MCO

- Receives C-9
- Determines if C-9 can be processed
- Applies ODG and treatment guidelines
- Determines relatedness
- May ask provider for additional medical

BWC

- May require BWC secondary review
- If review required, notifies MCO of support

MCO

- Completes approval determination

C-9 Treatment Request for Authorization

Potential areas of BR issues:

- Use of name brand for equipment instead of a general description of service/equipment/need.
- Use of unlisted code(s).
- Lack of justification (i.e., frequency or duration).
- Cost reasonableness of services being requested.

Provider Reimbursement Resources

- BWC's website www.bwc.ohio.gov
- Health Partnership Program Rules: Ohio Administrative Code 4123-6
- Reimbursement Schedules
- Billing and Reimbursement Manual
  - Medical Reimbursement Policy
  - How to bill
  - Policy alerts
- National standards

The Billing and Payment Process

MCO → **BWC** → **MCO**

MCO
- Receives bill fax, electronically
- Determines if bill can be processed
- Applies clinical editing and UR
- Applies fee schedule
- Sends 837 to BWC for final processing

BWC
- Finalizes payment returns 835 to MCO
- Deposits funds in MCO account

MCO
- Issues check/EFT and 835 to provider

Common Billing Denial Reasons

- Billed diagnosis code not allowed in the claim (#1 denial reason)
- Medical documentation is:
  - Missing or incomplete
  - Doesn’t support the medical necessity or relatedness
  - Doesn’t support the level of service billed (E&M)
- Correct coding not followed
  - Invalid use of modifiers
  - Provider not eligible to bill certain codes

Billing Tips to Remember

- The primary diagnosis on the bill determines what the provider is treating and
  - Must be allowed in the claim; or
  - Related to the claim.
- Medical documentation is necessary to:
  - Verify relatedness; and
  - Support the diagnosis.

Billing Tips to Remember

- Medical documentation may also be required to:
  - Verify levels of service.
  - Providers of service.
  - Appropriate coding.
  - Units of service.

Billing Tips to Remember

- Initial bill: One-Year Filing limit (**Date of service** based)
- Adjustment request: One year seven days following **MCO receipt** date of initial bill
  - Do not submit multiple copies of a bill as a means to submit an adjustment.

Bill Payment Appeals

Billing Grievance

- Dispute denial of a service
  - Coding
  - Authorization
  - Documentation

Can't dispute the fee schedule rate

Alternative Dispute Resolution

- Denied treatment request
- Denied bill for medical necessity

BRM- Chapter 1

Payment Appeals

- Two levels of bill grievance
  - 1st Level: MCO (email, fax, phone, or mail)
  - 2nd Level: BWC (email or phone)
    - BWC’s Provider Contact Center 1-800-OHIOBWC, option 0-3-0
    - Feedback.medical@bwc.state.oh.us
- If the appeal is in favor of the provider, the MCO will submit an adjustment to BWC.

Important Policy Updates

- Audio-only services
- Medical billing efficiency expected 2023
  - Expanding bill types accepted
  - Expanding date span billing for home health and long-term care

- OhioBWC - Provider - Service: (Billing and Reimbursement Manual)

Important Policy Updates

- Telemedicine (BRM-09) (New/Revised/Updated)
- COVID-19 Policy Alerts
- Provider Frequently Asked Questions

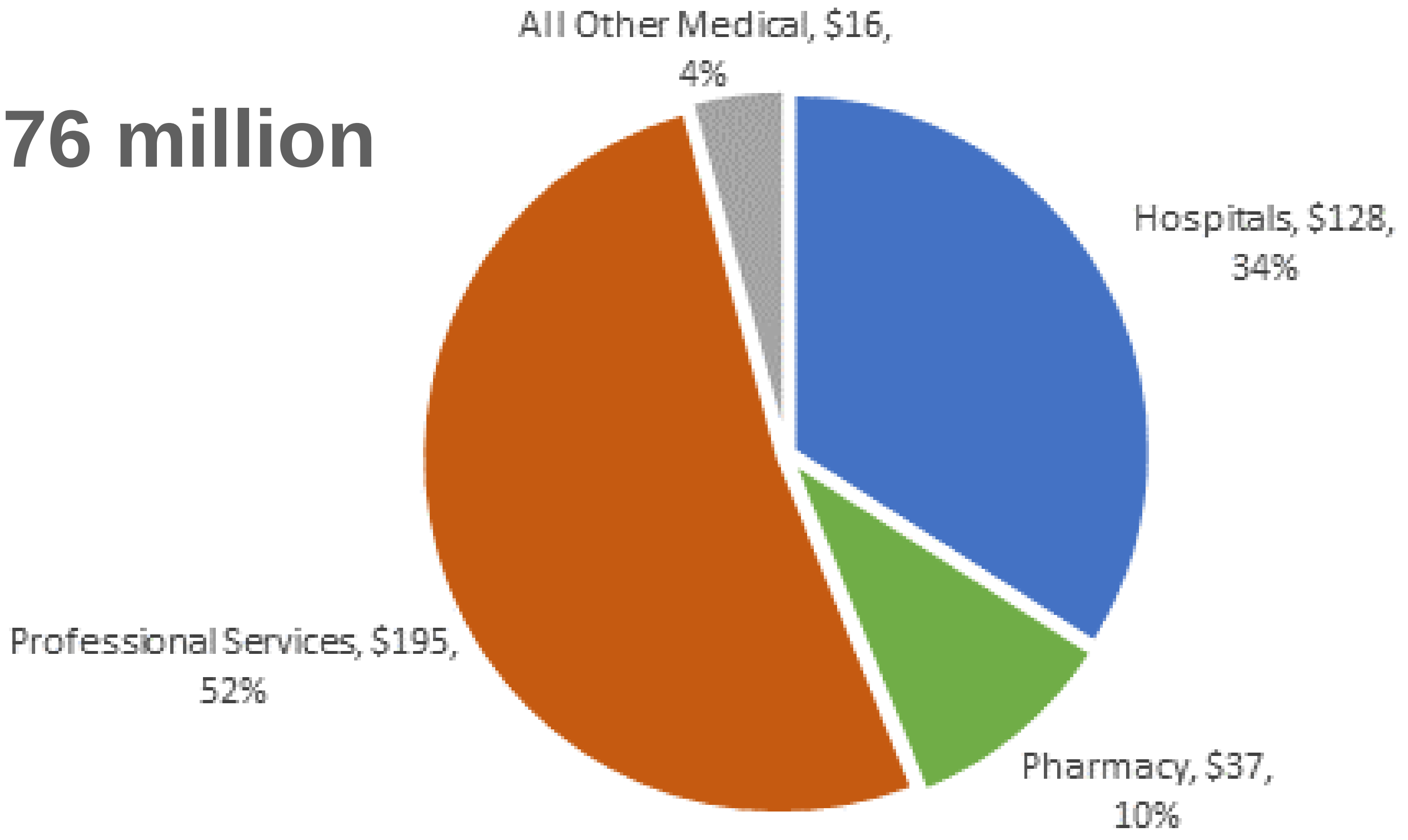
- OhioBWC - Provider - Service: (Billing and Reimbursement Manual)

- Questions?

Appendix

Total Medical State Fund Medical Services Spend: Fiscal Year 2021

$376 million



BWC Fee Schedule Development

Fee schedule	Effective date	Fee schedule description
Medical providers and services	Jan. 1, 2022	Covers all medical providers and medical services not covered by any of the other schedules. (OAC 4123-6-08)
Hospital outpatient	May 1, 2022	Covers facilities for outpatient services. (OAC 4123-6-37.2)
Hospital inpatient	Feb. 1, 2022	Covers facilities for inpatient services, (OAC 4123-6-37.1)
Ambulatory surgical centers (ASC)	May 1, 2022	Covers surgical procedures performed in an ASC. (OAC 4123-6-37.3)
Vocational rehabilitation services	Oct. 1, 2021	Covers all vocational rehabilitation services. (OAC 4123-18-09)

Provider Feedback / Questions

BWC Contacts

- Fee schedule e-mail inquiries
  - Fee schedule comments
  - Sign up for Provider e-news
  - Receive alerts when rule updates are released
  - BWCProviderFeedback@bwc.state.oh.us
- Provider contact center
  - 1-800-644-6292
  - Option 0 – 3 – 0
- SI e-mail inquiries
  - SIINQ@bwc.state.oh.us

How to Use the BWC Fee Schedule

- Fee schedule appendix (Professional Provider and ASC)
  - Fees and code coverage
  - Preamble: including modifiers with reimbursement implications or other reimbursement impacts
  - Medically Unlikely Edits (MUE)
  - Always therapy (professional provider)
  - Anesthesia base units (professional provider)
  - ASC quality reporting 2% penalty list (ASC)

How to Access and Use Fee Schedule Files

	L7499 - Manufacturer invoice price plus a negotiated percentage not to exceed 50%
Not Routinely Covered (NRC)	The procedure or service is not covered unless application of the *Miller* criteria requires an exception. See: OAC 4123-6-16.2(B)(1) through (B)(3). Where coverage is required, the pricing is listed on the fee schedule. If the pricing is listed at $0.00, the MCO shall perform a cost comparison to determine a reasonable price. The MCO shall utilize the price to negotiate a final reimbursement rate.
Never Covered (NC)	The procedure or service is never covered.
To Be Determined (TBD)	HCPCS codes noted as TBD (To Be Determined) will have pricing adopted when reimbursement rates are available from the Center for Medicare and Medicaid Services (CMS)
Negotiated	Negotiated reimbursement rates are required for designated all-inclusive per diem codes. Additionally, the MCO may need to negotiate a fee with a provider that will not accept the Ohio BWC fee schedule. In those situations, MCOs are required to attempt fee negotiation and document the provider discussion attempts. The services/supplies must be medically necessary for treatment of the work-related injury. Cost comparisons by the MCO for equitable reimbursement rates may often be necessary.
All Inclusive	All Inclusive means the service includes, but is not limited to, the examples noted for the code description.
Modifiers	BWC accepts all industry-standard modifiers as published with CPT codes by the AMA and published by CMS with HCPCS level II codes in effect on the billed date of service. The modifier code set includes 2-digit ambulance modifiers that specify trip origin and destination. Unless otherwise specified in this document, modifiers will not affect the fee schedule amount calculated for a procedure.
Modifier 22	Unusual procedural services. Procedures with this Modifier must be individually reviewed and

Preamble | Fees | Always Therapy | Base Units | Max units

Billing and Reimbursement Manual

BWC / **For Providers**

For Providers

Workers' Compensation Provider

- Understanding Medical Management
- Claims & Reimbursement
- Medical Treatment & Pharmacy Benefits
- Provider Forms
- COVID-19 Questions?
- All Providers Resources

Billing and Reimbursement Manual

1. Table of Contents
2. Quarterly Update Highlights
3. Chapters (traditional)
4. New/Revised/Updated Policies
5. Policy alerts

① Table of Contents

② Quarterly Update Highlights

Preamble

③ Chapter 1 - Ohio Bureau of Workers' Compensation System
This chapter includes information about employer types; managed care organization roles/resp
provider eligibility; reporting an injury; guidelines for treatment, coding and reimbursement; and
processes and procedures.
Presumptive approval guidelines
MCO standard prior authorization table
Medical documentation policy

MCO Directory

Chapter 2 - Services
This chapter includes information about practitioners, hospitals, ambulatory surgical centers, ou
medication, vocational rehabilitation, home health agencies, nursing homes and other BWC-cer
provider services.
Beryllium Policy
BWC Recognition of ICD-10-CM Codes for "Pain"
Cardiac Clearance for Non-Cardiac Surgery
New Medical Technologies and Procedures

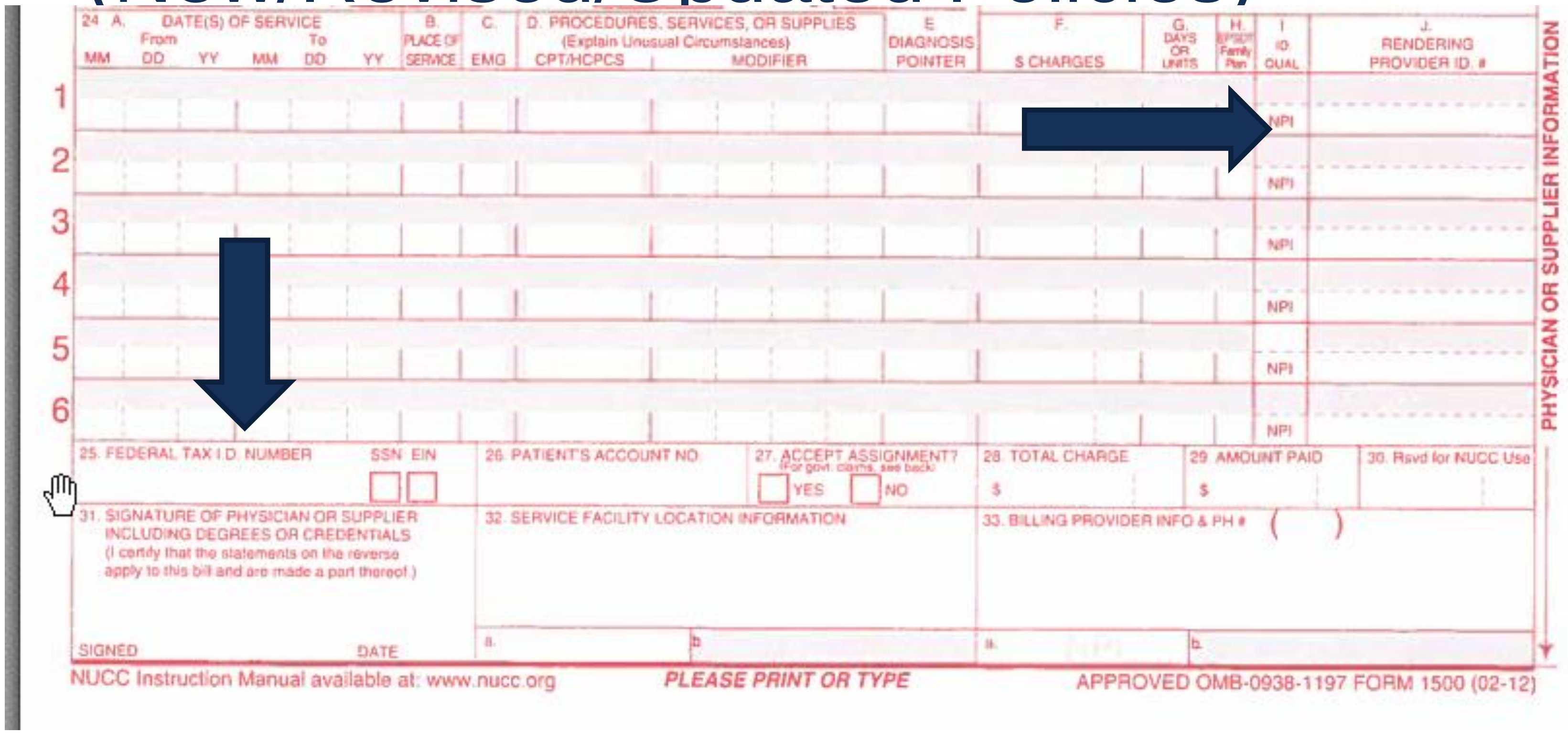
Chapter 3 - Vocational Rehabilitation Services
This chapter includes information about vocational rehabilitation services.

④ New/Revised/Updated Policies

⑤ **Policy alerts**
BWC will periodically issue policy alerts to provide further clarification on specific policies. To dc
latest policy alerts, click on any of the links below.

Important Policy Updates

- BRM-26 General billing guidelines (New/Revised/Updated Policies)



24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI
2 NPI
3 NPI
4 NPI
5 NPI
6 NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION
a. b.
33. BILLING PROVIDER INFO & PH # ( )
a. b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

C-9 Treatment Request Disagreement

- Alternative Dispute Resolution (ADR) Process
  - Designed to handle medical disputes regarding:
    - Quality assurance.
    - Utilization review.
    - Medical necessity.
    - Other treatment and provider issues.
  - Can be initiated by provider, employer, employer's representative, injured worker or injured worker's representative.
  - Contact the MCO in writing.
  - One independent level of professional/peer review.