



**SUBJECT: Pennsylvania Workers' Compensation Medical Fee Schedule Third Quarter Update**

CHARGEMASTER DISTRIBUTION DATE: **June 21, 2022**

TO: Medical Fee Schedule Users

FROM: Bureau of Workers' Compensation Healthcare Services Review Division

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**COVID-19**

As Covid-19 related billing codes become available, we add the codes to the fee schedule. When no rate has been established for a code, please refer to §127.102 of the Medical Cost Containment regulations regarding payment.

**WORKERS' COMPENSATION AUTOMATION & INTEGRATION SYSTEM  
CUSTOMER SERVICE FEATURE**

The Workers' Compensation Automation & Integration System (WCAIS) Customer Service Center feature in the upper right corner of the WCAIS Dashboard directs users to the central hub for all WCAIS information such as Frequently Asked Questions; Process Guides and Video Simulations; and Previously Recorded Trainings. All users have the ability to submit inquiries via the Customer Service Center. Users must register in WCAIS to gain additional access to the system.

To register as a user in WCAIS go to [www.wcais.pa.gov](http://www.wcais.pa.gov) and click on "I am new user" and follow the prompts.

\*Please note that you, or someone from your organization, must be registered in an administrator role within WCAIS *before* you can be registered in a WCAIS user role. The administrator role is issued a PIN number which is entered during user registration to ensure individuals are associated with the correct organizations. Make sure to have your PIN number onhand when you are ready to register as a user.

**NOTICE TO ALL PAYERS – HEALTH CARE SERVICES REVIEW CONTACT EMAIL**

Upon acceptance of a medical fee review application, an email is sent to the Health Care Services Review Contact email address identified in your WCAIS profile indicating a Letter of Investigation requesting your input is present on your WCAIS dashboard. This will be the only email contact from the Bureau you receive regarding the Letter of Investigation.

It is your responsibility to ensure your organization's Health Care Services Review Contact email address remains current, and that the information provided within Bureau emails is disseminated internally to the appropriate parties.

## RESPONDING TO MEDICAL FEE REVIEWS

All fee review responses should be uploaded directly in WCAIS. Delays associated with responses received by fax, email, or USPS may prevent the response from being considered when the fee review determination is rendered.

To be automatically notified when the Bureau has received a fee review involving your organization, it is as simple as

- Making sure you are registered in WCAIS.
- Maintaining your WCAIS profile Health Care Services Review Contact Email with up to date correct email(s) addresses.

If you are having difficulty responding:

- Make sure you are logged in using the right Keystone ID for the fee review you are trying to respond to.
- If another individual representing the payer responded using the Med Fee Fact Finding Tab found in the Quick Links section of your dashboard, the link will be closed. You can still provide a response by going directly to the Documents and Correspondence tab and uploading your information there.
- If you need to communicate additional information, simply write it down, convert the document to a PDF, and upload the PDF.
- If you are still having difficulty accessing or finding the fee review, please contact [RA-LI-BWC-HCSR@pa.gov](mailto:RA-LI-BWC-HCSR@pa.gov).

## ATTENTION MEDICAL FEE REVIEW PARTIES

### Medical Fee Review Correspondence

All Medical Fee Review correspondences and notices are available via email notification, the WCAIS Dashboard, and/or located within the individual Medical Fee Review matters.

**Important:** If your profile allows you to enable the electronic correspondence format, please ensure the radio button on your profile is checked next to “Email.” If you do not enable this function, you will continue to receive a paper copy of all the correspondence via the United States Postal Service. It is important to begin managing your profile to support electronic communications as we transition our processes to support 100% online operations.

**Return of Premature Applications for Medical Fee Review**

Per 34 Pa. Code § 127.255, the Bureau must return the applications for fee review when:

- The insurer denies liability for the alleged injury (including treatments denied as not causally related)
- A pending utilization review for the treatment in the medical fee review application
- The 30-day period allowed for payment has not yet elapsed, as computed under § 127.208 (relating to payment of medical bills).

Please note that the requirement is for the Bureau to return the entire application, so if any portion of the application is associated with the above criteria the entire application will be returned.

**PROVIDERS IMPORTANT: Mandatory LIBC-9**

In accordance with 34 Pa. Code Section 127.203(d) if a provider does not submit the LIBC-9 medical report form, the insurer is not obligated to pay for the treatment covered by the report until the required report is received by the insurer. 34 Pa. Code Section 127.253(a)(2) indicates the medical report form should be included with fee review applications. Make sure the date on the LIBC-9 submitted for fee review accurately reflects the date it was originally submitted to the carrier for the bill(s) undergoing fee review or the timeliness outcome of the fee review may be affected.

**Necessity of Billing with Block 17 Qualifier**

The utilization review process is the exclusive way to challenge the reasonableness and necessity of medical bills of a workers' compensation claimant. In *Schenck v. WCAB (Ford Electronics)*, 937 A.2d 1156 (Pa. Cmwlth. 2007) the court held a utilization review determination is specific to the provider, not the treatment under review. In the cases where individuals render supervised treatment because the scope of their license precludes independent practice, the utilization review is performed on the supervising provider. Likewise, when the treatment involves anesthesia, incident to surgical procedures, diagnostic tests, prescriptions or durable medical equipment, the utilization review is performed on the referring, ordering, or prescribing provider.

**The ability to identify the relationship between a provider's bill and applicable utilization reviews requires CMS 1500 bills to include box 17 information that clearly indicates the supervising provider for services rendered by a dependent licensed provider and the ordering provider when addressing treatments such as medications and durable medical equipment.**

Guidance from CMS published October 13, 2017, indicates the supervising or ordering physician is to be documented in block 17. Critical to correct completion of block 17 is the documentation of the appropriate qualifier to the left of the dotted vertical line on item 17.

Qualifier	Provider Role
DQ	Supervising Provider
DK	Ordering Provider
DN	Referring Provider

*When a treatment is associated with an individual who may only provide the service under the supervision of another provider, **the bill may result in denial** if block 17 is not correctly completed. Similarly, when a treatment, such as a medication or durable medical equipment, is billed without block 17 containing information on the ordering provider, **a denial may result**.*

### **J Codes**

Effective for dates of service on or after July 1, 2017 the Bureau has removed all J codes from the Part B fee schedule per §127.131(a) of the regulations, which states payments for all prescription drugs and pharmaceuticals are paid at 110% of the AWP. Because J code reimbursement is not calculated this way, it is incorrect to use these codes for billing or reimbursement of PA Workers' Compensation.

Drugs and pharmaceuticals previously billed with J Codes should be billed or downcoded to a valid NDC associated with an AWP and reimbursed per §127.131(a).

### **DRG Grouper**

As indicated in §127.154(b), the DRG Grouper was frozen for purposes of workers' compensation inpatient claims. Medicare Grouper 12 was the version in effect on December 31, 1994 and will remain the authorized grouper for all inpatient workers' comp medical claims. Additions, deletions or modifications to the ICD-9 codes used to determine the DRG shall be mapped to the appropriate DRG within the frozen grouper. ICD-10 codes must be crosswalked as needed to ICD-9 in order to allow for all DRG charged admissions to be crosswalked to a Grouper 12 DRG for the purposes of billing and downcoding.

### **National Provider Identifier (NPI)**

WCAIS relies on healthcare providers' and professionals' NPI numbers for identification.

- Please verify your WCAIS profile includes your NPI. If you do not have an NPI, you may obtain one at [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov)
- If you are having difficulty entering NPI information, please email your information to [RA-LI-BWC-HCSR@pa.gov](mailto:RA-LI-BWC-HCSR@pa.gov).

### **Medicare Provider Number Availability**

Per § 127.101(e), medical fee caps based on Medicare will apply to all health care providers licensed in this Commonwealth who treat injured workers, regardless of whether the health care provider participates in the Medicare Program. When a Part A provider enrolls in the PA Workers' Compensation Chargemaster, if the Medicare Provider Number is available, it will be identified in the Chargemaster. When a Part A provider does not participate with Medicare, the organization will be assigned a surrogate number beginning with the letters BWC and followed by a three-digit numerical extension (i.e., BWC001, BWC002). This number solely serves as a place holder as the NPI number is the Bureau's primary identifier within the Chargemaster.

## **ATTENTION ALL PROVIDERS INVOLVED IN MEDICAL FEE REVIEW DISPUTES**

### **Incorrect Filing**

In addition to the premature filing reasons identified in § 127.255, applications for fee review will also be returned for the reasons below:

- Documentation associated with more than one worker/patient
- Whenever a single CMS 1500 form includes dates of service that were billed on different dates
- Missing bills for requested the dates of service requested for review
- An application that has bills for more than one professional, e.g., Block 31 must be the same for all of the CMS 1500s included in the application
- When the proof of service is not completed. The proof of service must include:
  - Date copy of application sent
  - Name and address of who the copy of the fee review was sent to
  - The method used to send the copy
  - The provider or provider representative signature, printed name, and telephone contact
- **Please know that when you are resubmitting an application that was returned, you must complete an entirely new proof of service. For clarity, the old proof of service should not be included in the resubmitted application. If you do not submit a new proof of service with your resubmission your fee review application will be returned again.**

### **Withdrawing Fee Reviews**

If you have filed an Application for Fee Review (by paper or online through WCAIS) and receive satisfactory payment before the fee review decision is issued, you may withdraw your fee review. Please note that a fee review application can only be withdrawn in its entirety, so if there are still dates of service in the application you require a fee review decision on, the application should not be withdrawn. All fee reviews filed may be withdrawn via WCAIS. If you are having difficulty withdrawing a fee review, contact the Bureau by emailing [RA-LI-BWC-HCSRd@pa.gov](mailto:RA-LI-BWC-HCSRd@pa.gov) and enter Withdraw Fee Review in the subject line.

### **TENS SUPPLIES**

Per CMS guidelines, Transcutaneous Electronic Nerve Stimulator (TENS) Supplies (billed under HCPCS code A4595) should not be unbundled. HCPCS code A4595 is a bundled code established to provide reimbursement for all routine supplies provided to a patient on a monthly basis. If 2 TENS leads are utilized, then a maximum of one unit of Code A4595 would be allowed per month; if 4 TENS leads are utilized, a maximum of two units per month would be allowed.

CMS has indicated that intentional unbundling is a type of fraud. Under §127.204 of the PA Workers' Compensation Cost Containment regulations, providers may not unbundle except as consistent with Medicare. Providers and payers may wish to refer to CMS for further guidance.

## **TIME BASED CODES**

**(codes with descriptions specifying an increment of time such as minutes or hours)**

- A unit of time is attained when the mid-point is passed.
- For any time-based procedure codes, the duration of the service must be clearly documented in the medical record.
  - Documentation solely in terms of “units” is deficient in establishing the amount of time the service was rendered.
  - Utilization of time ranges (e.g., 5-10 minutes) may be insufficient to support documentation of time/duration.
  - Consistent with CMS guidance, the actual number of minutes or begin-to-end times should be documented to establish the duration of the services rendered.
- Remainders of *different* time-based codes may *not* be utilized to calculate cumulative charges for billing purposes.

## **PPO NETWORKS IN PENNSYLVANIA WORKERS' COMPENSATION**

Please be advised that neither the Workers' Compensation Act nor the Department regulations address PPOs. The Fee Review section cannot address either parties' obligation under a private agreement.

## **2022 FEE SCHEDULE**

The 2022 fee schedule has been updated by the percentage of change of the statewide average weekly wage, which is **6.6 (%) percent**. All payers are reminded that this percentage of change applies to all services rendered on or after January 1, 2022.

### **To all Registered BWC Chargemaster Subscribers and Recipients**

Tables A, C, D, F, G and I (Cost Allowance Table) are for calendar years 2021 and 2022 only. It is your responsibility to maintain prior versions of the Medical Fee Schedule for processing payment for treatments rendered before 2021.

### **For all BWC Fee Schedule Website Users**

The fee schedule examples published online are courtesy copies and contain only the calendar year 2022. It is your responsibility to maintain prior versions of the Medical Fee Schedule for processing payment for treatments rendered before 2022. The complete fee schedule can be purchased from the Bureau's vendor by contacting MM Associates, LLC at [mmassociatesllc@aol.com](mailto:mmassociatesllc@aol.com).

### **Red Book**

When rendering medical fee review decisions, the Bureau currently utilizes Red Book, published by IBM Micromedex, to determine the AWP for calculation of payments for prescription drugs and pharmaceuticals in accordance with §127.131.

**FAIR Health**

According to §127.102, if a Medicare payment mechanism does not exist for a particular treatment, accommodation, product or service, the amount of the payment made to a health care provider shall be either 80 percent of the usual and customary charge in the geographic region where rendered, or the actual charge, whichever is lower. When rendering medical fee review decisions, the Bureau currently utilizes the 85th percentile of the MDR (medical data retrieval) database published by FAIR Health to determine the usual and customary charge.

**2022 QUARTERLY UPDATES**

Please note that the availability of code sets, CMS corrections, and/or other administrative issues may result in a delay in the anticipated distribution date or the need for an updated version of the Medical Fee Schedules to be issued.

A provider's Chargemaster can only be guaranteed to be updated in time for the quarterly distribution when the provider adheres to following submission date schedule:

<b>Submission</b>	<b>Anticipated Distribution</b>
November 1st	December 15th
February 1st	March 15 <sup>th</sup>
May 1st	June 15 <sup>th</sup>
August 1st	September 15th

**The Bureau has transitioned to 100% electronic submission.**

**Important Provider Clarifications**

1. If a provider has deactivated a service code that is currently in the official BWC’s Chargemaster, the provider may **not** re-use this code for a new service. For any new service, the provider must create an entirely new service code that was never previously provided to the BWC.
2. Medicare Acute Care Hospitals that have an inpatient sub-unit, either rehab and/or psych (Medicare numbers 39T and 39S respectively), must submit to the Bureau the Chargemaster data unique to the sub-unit under their assigned 39T and 39S Medicare Part A provider number (i.e. room & board, etc.) to be reimbursed for these services. Failure to identify specialty hospitals with the “S” or “T” on Chargemaster data may result in payment delays or incorrect reimbursement.
3. For those providers that submitted an update, the enclosed CD will include two (2) tables: BASE.TXT and SUBMIT.TXT. The **BASE.TXT** is your official BWC Base File and the **SUBMIT.TXT** is your submission file for this quarter. If you have a BWC registered subunit (39S and/or 39T), you will not receive a separate CD for these subunits as the information is identical to the Acute-Care Hospital. We will indicate the subunits on the CD label of the Acute-Care hospital.

**Help with Submission**

For provider instructions on how to submit information to the Bureau for future updates, obtain a schedule of submission deadlines, fee schedule distributions, and/or an order form to purchase the fee schedule(s), please contact the Bureau’s vendor, MM Associates, LLC, at [mmassociatesllc@aol.com](mailto:mmassociatesllc@aol.com).

**Out of State Providers**

Medical fee caps for out of state providers have been included in this update based on the Medicare reimbursement rates applicable in **Harrisburg, Pennsylvania**. Payment is to be made pursuant to §127.129. The following schedule indicates the provider number that has been assigned to the out of state provider in each individual fee schedule:

<u>Provider Number</u>	<u>Fee Schedule</u>	
999993	Table A	PPS Table
999995	Table C	Skilled Nursing Facility Table
999991	Table D	Home Health Agency Table
999990	Table F	ASC Table
999996	Table G	Physical Therapy per Visit, Outpatient End-Renal Dialysis and Hospice Table
999994	Table J	Out-of-State Frozen RCC and Per Diem



### **Tables Used to Price Part A Services**

For all new 2022 fields in each fee schedule, please refer to the table structures in the Workers' Compensation Manual in PDF format provided on the Distribution CD or email.

Please remember, your Part A fee schedule distribution will only include the 2021 and 2022 payment rates. It is your responsibility to maintain prior versions of the fee schedule/Chargemaster for processing payment for treatments rendered before 2021.

In addition, the tables and schedules used in the pricing of Part A services have been updated to reflect the 2022 percentage change in the statewide average weekly wage (**6.6 (%) percent**) along with NPI updates.

The Bureau of Workers' Compensation provides Tables A through H in an ASCII comma delimited format on a CD. The specific provider **additions or deletions for this quarter** are identified below:

**Table A      Prospective Payment System Table**

NPI #1164029658 (390336) Added.

NPI #1164029658 (BWC007) Deleted.

**Table B      Federal Register Table**

No Changes.

**Table C      Skilled Nursing Facility Table**

No Change.

**Table D      Home Health Care Agency Table**

No Changes.

**Table E      Ambulatory Surgical Center of Payments**

Note: This table has been discontinued.

**Table F      Ambulatory Surgical Center Table of Providers**

NPI #1306434998 (BWC008) Added.

NPI #1568060655 (391367) Added.

The Bureau reminds all payers and providers that reimbursement rates, pursuant to Act 44 of 1993, were capped based upon 1994 allowances. The CMS Special Payment Rule for ASC multiple procedures (56 FR 23021 May 20, 1991), which was in effect in 1994, provides that when **two or more procedures** are performed, the ASC will be reimbursed at the full rate for the procedure classified in the highest payment group. Any other procedures performed during the same session will be reimbursed at 50 (%) percent of the procedure's applicable group rate. If the procedures are within the same group, the ASC will be reimbursed at the full rate for one procedure and at 50 (%) percent of the rate for the others.

**Table EF-1    ASC Approved Procedure Listing**

No Changes.

**Table G      Physical Therapy/Renal Dialysis/Hospice Table**

No Changes.

**Table H      Pharmacy RCC Table**

NPI #1164029658 (390336) Added.

NPI #1164029658 (BWC007) Deleted.

### **Revenue Code Alerts**

When service codes within the following revenue code ranges are reported by providers, payers shall, when applicable, utilize the Part B fee schedule or other appropriate pricing tables rather than Table I of the Part A fee schedule package:

#### *Pharmacy Items (Revenue Codes 250-259 and 630-639)*

Reimbursement for pharmacy items is based upon the multiplication of the submitted charge by the frozen Pharmacy RCC (Table H) and then by 113 (%) percent.

#### *DME and Clinical Laboratory Services (Revenue Codes 290-309)*

Reimbursement based on the Part B physician fee schedule using the reported CPT/HCPCS procedure codes.

#### *Professional Fees (Revenue Codes 960-989)*

Reimbursement based on the Part B physician fee schedule using the reported CPT procedure codes.

### **Non-reimbursable Revenue Codes**

#### *Patient Convenience Items (Revenue Codes 990-999)*

Patient convenience items are non-reimbursed for workers' compensation purposes.

### **Other Revenue Code Requiring Special Attention**

#### *Emergency Room (Revenue Code 450)*

The only Emergency Room services billable under workers' compensation are the Level of Care (99281-99285 and 99291-99292) and their corresponding service codes as found in the official Bureau Chargemaster.

**PLEASE NOTE:**

If there are any questions concerning the third quarter distribution data, please contact:

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