TITLE 631 WORKER'S COMPENSATION BOARD OF INDIANA

NOTE: 631 IAC was transferred from 630 IAC. Whenever in any promulgated rule text there appears a reference to 630 IAC, substitute 631 IAC.

631 IAC 1-1-32 Medical provider fee claims

Authority: IC 22-3-1-3

Affected: IC 22-3-3-5

Sec. 32. The board, under IC 22-3-1-3, and in order to regulate proceedings under IC 22-3-3-5, adopts the following:

(1) The following definitions shall apply:

(A) "CMS" refers to Centers for Medicare and Medicaid Services, an agency of the U.S. Department of Health and Human Services.

(B) "CPT" refers to the current procedural terminology manual published annually by the American Medical Association.

(C) "Payer" means an agent, a designee, an employee, an assignee, or an independent contractor of the employer including a billing review service utilized by the payer for services performed under the act.

(D) "Written communication" means the written statement made by a payer to a health care provider, in response to a claim for payment submitted to the payer by the provider, wherein the payer notifies the provider of the payer's determination of the employer's pecuniary liability for the medical treatment, services, and supplies that comprised the provider's claim for payment.

(2) Payment of medical benefits shall be made as follows:

(A) Where the compensability of billed services is not contested, payment for billed services shall be as follows:

(i) Providers shall submit bills for services rendered within one hundred twenty (120) days of the date of service. Bills submitted by providers for payment shall state the provider's actual charges for the treatment rendered. A provider's statement of actual charges is not to be construed as a request for payment in excess of the medical fee cap or schedule. The billing statement must be in detailed line item form. The payer to whom the bill is submitted shall calculate the proper amount of the payment for the treatment rendered.

(ii) Unless contested in accordance with the provisions set forth in this section, all bills submitted by a provider are due and payable in accordance with IC 22-3-3-5 within ninety (90) days after receipt of the bill by the payer. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) days after the date the bill was mailed to the payer's correct address. Payer may request additional documentation to support medical bills submitted for payment by the provider, as long as the additional documentation is relevant to the treatment for which payment is sought. If a payer requests additional information or records from a provider, the ninety (90) day period shall be tolled until the documentation is received by payer.

(iii) The payer shall supply a written explanation of review (EOR) to the provider describing the calculation of payment of medical bills submitted by the provider. If payment is based on changes to a provider's codes, the EOR shall specifically state the justification for changing the original codes. If payment of a bill is denied entirely, the payer shall provide a written, detailed explanation for the denial of each covered item.

(B) If the payer agrees a service or procedure was reasonable and necessary, the provider's lack of prior authorization for payment does not warrant denial of liability for payment of the appropriate amount due under the act.

(C) The payer may only make changes to a provider's billing codes consistent with American Medical Association (AMA) guidelines and definitions in CPT coding instructions, Medicare guidelines, the act, and the Indiana Administrative Code.

(3) Medical bill disputes shall be addressed as follows:

(A) When the payer fails to make timely payment of uncontested billed services, the provider shall first attempt to resolve payment with the payer or the medical review service, or both, by any means set out in a relevant contract between the parties and those steps set out on the board's website. Where such attempts are

unsuccessful, the billing party may request assistance from the board by first contacting the board's medical claims reviewer and thereafter filing an application for adjustment of claim for provider fee (application) if necessary.

(B) In all cases where a billed service is contested by the payer, the payer shall, within ninety (90) days of receipt of the bill, submit to the provider a written notification of contest setting out the reason for denial.

(C) The written notification of contest shall include the following information:

(i) The name of the injured worker.

(ii) The date or dates of the service or services being contested.

(iii) The payer's accident number or board's claim number, or both, if applicable.

(iv) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services.

(v) Reference to the bill and each item of the bill being contested.

(vi) The reason or reasons for contesting the payment of any item. The explanation shall include the citing of appropriate statutes, rules, and documents supporting the payer's reasons for contesting payment.

(D) The provider shall have sixty (60) days to respond to the payer's written or electronic notification of contest. Thereafter, the payer shall have thirty (30) days to respond to the provider's response to the notification of contest. If the parties are unable to resolve a dispute relating to the correct payment of a bill, an application may be filed after first contacting the board's medical claims reviewer for assistance.

(4) The responsibilities of the provider seeking adjudication of a claim for fees shall be as follows:

(A) Prior to filing an application, the medical provider, the employer, its insurer, and/or its billing review service must engage in a good faith attempt to negotiate an agreed payment.

(B) When seeking clarification or dispute resolution from the board, the provider must provide the following upon the request of the board:

(i) The fully completed and signed provider fee application, which must identify the specific charges for which provider seeks (additional) reimbursement beyond any reimbursement allowed by the payer.

(ii) A copy of CMS 1500 or UB04, whichever is applicable, or its replacement.

(iii) A copy of the first and final requests for reimbursement by the provider to the payer. These requests must indicate the following:

(AA) The name and address of the person contacted.

(BB) The employee's name, address, and date of service.

(CC) Any other information that will assist the carrier or employer in identifying the claim.

(iv) All information submitted by the provider to the payer including a detailed copy of the bill with the contested codes and dates of service in dispute.

(v) A complete copy of the payer's explanation as to why the billed services are being contested.

(vi) Documentation of provider and payer's negotiation proceedings and independent attempts to settle the matter.

(vii) A copy of all relevant medical record documentation.

(viii) Applications submitted without all of the necessary documentation will not be filed.

(C) The provider shall furnish a copy of the application and all attachments to the employer, its insurer, or the billing review service if designated by the employer or its insurer.

(5) The payer's responsibilities in the adjudication of a claim for medical fees shall be as follows:

(A) Within thirty (30) days of the filing of providers' application, the payer must submit to the board a written response setting forth the reasons that (additional) reimbursement is not required. Evidence rebutting the provider's demand shall accompany its response, including the data relied on to adjust the bill, if relevant.

(B) The payer shall furnish the provider with copies of the evidence provided to the board in response to the provider's application. Thereafter, within thirty (30) days of the filing of the payer's response, the provider shall file with the board rebuttal evidence, if any, it intends to use in support of its claim.

(6) Multiple procedures. When performing more than one (1) surgical procedure in a single surgical setting, multiple surgery guidelines (one hundred percent (100%) of the listed value for the primary procedure and fifty percent (50%) of the listed value for additional procedures) shall apply. The fifty percent (50%) reduction does not apply to procedures that are identified in the applicable edition of the CPT as "Add-on" or Modifier 51-exempt procedures.

(7) Fragmenting or unbundling of charges by providers. A provider may not fragment or unbundle charges except as consistent with AMA guidelines, CPT coding instructions, or Medicare rules and regulations.

(8) Payment for out-of-state medical treatment of the injured worker shall be made as follows:

(A) Out-of-state medical providers treating injured employees pursuant to the Indiana act shall be reimbursed according to the worker's compensation act of Indiana and these administrative provisions. The filing of a first report of injury with the board shall be prima facie proof of jurisdiction in Indiana.

(B) When an injured employee is treated outside of Indiana, the applicable fee shall be that which would apply if the care had been provided in this state, at a location with a similar population and medical community as that of the location of care. If such comparison is not possible or practicable, reimbursement shall be that which would apply in the community defined as the geographic service area served by the Zip codes with the first three (3) digits 462. Categorization of a hospital or facility provider according to any Indiana standards shall also apply.

(9) Reimbursement for special reports shall be as follows:

(A) Payment shall be made for special reports (CPT code 99080) only if these reports are specifically requested by the payer. Office notes and other documentation that are necessary to support billed provider codes may not be considered special reports.

(B) Payment for special reports shall be at one hundred percent (100%) of the provider's usual and customary charge.

(10) Surgical assists. Assists in surgery will be reimbursed if indicated by the relevant surgical specialty society, CMS, or Medicare guidelines as medically necessary. The rate of reimbursement is indicated by attaching modifier 80, 81, or 82 to surgical procedures. Reimbursement for procedures modified by 80 or 82 will be at twenty percent (20%) of the applicable fee schedule or rate for the code presented. Reimbursement for procedures modified by 81 will be made at ten percent (10%). Multiple and bilateral procedure rules apply.

(11) Utilization review. The board recognizes the Utilization Review Accreditation Commission's (URAC) Workers' Compensation Management 2008 guidelines to medical utilization practices, as well as the Official Disability Guidelines (ODG) published by the Work Loss Data Institute and the American College of Occupational and Environmental Medicine (ACOEM) guidelines. Recommendations from these, and other, reputable sources may be offered as one (1) form of evidence regarding appropriate medical care; however, it will not be considered as conclusive evidence by the single hearing member or the full board.

(Worker's Compensation Board of Indiana; 631 IAC 1-1-32; filed May 4, 2012, 10:15 a.m.: 20120530-IR-631110357FRA)