

Pennsylvania Workers' Compensation Billing Tutorial

Step 1: Find the Charge Classes by Zip Code

http://www.portal.state.pa.us/portal/server.pt/community/charge_classes_by_zip_code/10428

The Pennsylvania Workers' Compensation Fee Schedule for Part B providers uses as its base fees the 1994 Medicare Fee Schedule. This fee schedule divides fees into four geographic regions. The links below contain all of Pennsylvania's zip codes and provides the correct region for each. Because this list is no longer used by Medicare, as they have developed different payment policies since 1994, it is no longer available through the Medicare intermediaries. Therefore, the Bureau of Workers' Compensation provides this reference as a service to the insurance and medical communities that are involved in workers' compensation so that a provider's region can be easily obtained.

The major users for this list are those who re-price medical bills to the workers' compensation fee schedule, including insurance carriers, employers who are self-insured for their workers' compensation insurance, third-party administrators, and re-pricing vendors. Medical providers may also use this list as a reference in determining if their payment amount is correct.

[15001 - 15963](#) [16001 - 16950](#) [17002 - 17985](#) [18001 - 18981](#) [19001 - 19611](#)

Example: Provider ABC in zip code 15001 would be a charge class/region 002 provider.

Charge Classes by Zip Code 15001-15963

Zipcode	Charge Classes						
15001	002	15003	002	15004	004	15005	002
15006	003	15007	003	15008	002	15009	002
15010	002	15012	003	15013	002	15014	002
15015	002	15016	002	15017	002	15018	002

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Step 2: Medical Fee Review Information

Workers' Compensation Act 44 and Act 57 provide employer/insurers with the opportunity to apply a medical fee schedule to workers' compensation medical payments. Information can be accessed at:

http://www.portal.state.pa.us/portal/server.pt/community/fee_schedule/10424

Included at the site is the 2010 Pennsylvania Workers' Compensation Fee Schedule for Part B providers as well as Tables A through H (Prospective Payment Table, Federal Register Table, Skilled Nursing Facility Table, Home Health Care Agency Table, Ambulatory Surgical Center Table, Ambulatory Surgical Center Table of Providers, Physical Therapy Per Visit Table and Pharmacy RCC Table) Table I. The Part A Charge master is not available at this site and can be obtained by calling the Bureau's Medical Fee Review Section at 717-787-3486.

Medical providers are required to request payment either on the HCFA form 1500 or the UB92 form, or any successor forms required by HCFA, and shall state their actual charges. The Employer/Insurer to whom the bill is submitted should calculate the proper amount of payment and supply a written explanation of benefits (EOB) to the provider. Payments for treatment rendered under the act must be made within 30 days of receipt of the bill and report. If payment is denied entirely, Employers/Insurers must provide a written explanation for the denial.

If providers do not receive timely or correct payment, an Application for Fee Review may be filed with the Department within 90 days of original billing or 30 days from date of dispute notification.

Example: Provider ABC in region 002 is billing a 99204 for an initial office visit, level 4:

	PART B	PART A TABLES								
HTML	Part B	A	B	C	D	E	EF-1	F	G	H
		Provider #390001 to #390125 Provider #390127 to #99993	DRG #1 to #200 DRG #201 to #400 DRG #401 to #495	Provider #395001 to #395421 Provider #395422 to 395700 Provider #395701 to #99995	Provider #397001 to #397301 Provider #397400 to #99991	Provider #54745 to #188024	ASC Procedure Table	Ambulatory Surgical Centers Providers	Physical Therapy Per Visit Based Provider	Pharmacy RCC
Excel	ptb.xls	pps.xls	table5.xls	snf.xls	homehlth.xls	ascgrp.xls	asclist.xls	ascprov.xls	physther.xls	pharmrcc.xls
1-2-3	ptb.123	pps.123	table5.123	snf.123	homehlth.123	ascgrp.123	asclist.123	ascprov.123	physther.123	pharmrcc.123

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Found at:

http://www.portal.state.pa.us/portal/server.pt/community/fee_schedule/10424

Once the Part B Fee Schedule is accessed this screen will appear:

[Workers' Compensation](#) > [Medical Treatment Information](#) > [Fee Schedule](#)

2010 Workers' Compensation Part B Fee Schedule

100-842

100-842	844-1820	1829-11643	11644-15321	15330-19103	19105-21014	21015-21435	21436-22849
22850-24073	24075-25109	25110-25920	25922-26565	26567-27178	27179-27468	27470-27750	27752-28264
28270-29358	29365-30620	30630-31635	31636-33211	33212-33676	33677-35011	35013-35601	35606-36578
36580-38564	38570-42227	42235-43261	43262-44145	44146-45331	45332-47130	47135-49423	49424-50551
50553-51784	51785-53510	53515-55520	55530-57511	57513-59100	59120-61520	61521-62161	62162-63286
63287-34766	64771-66150	66155-67880	67882-69643	69644-70460	70460-71111	71120-72157	72158-73206
73218-74022	74150-74410	74415-75716	75722-75945	75946-76519	76529-76941	76942-77285	77290-77787
77789-78261	78262-78605	78606-80436	80438-84630	84681-87400	87420-88333	88334-90847	90849-92135
92136-92626	92627-93312	93313-93619	93620-94005	94010-95806	95807-95933	95934-97016	97018-99347
99348-A4708	A4709-D5225	D5226-E0660	E0665-E2318	E2311-J1890	J1930-L1660	L1680-L5999	L6000-V5364

The CPT code information is accessed by clicking the hyperlink range that contains code 99204: [97018-99347](#)

Scroll down to code 99204:

CPT/HCPC Code	Modifier	Medicare Location	Global Surgery Indicator	Multiple Surgery Indicator	Prevailing Charge Amount	Fee Schedule Amount	Site of Service Amount
99204		1	XXX	0	0	17169	14530
99204		2	XXX	0	0	15999	13586
99204		3	XXX	0	0	14357	12223
99204		4	XXX	0	0	14137	12033

Region 002 is reimbursed \$159.99 if the service is performed at the provider's office. Refer to the section below on Site of Service Amount for further explanation of reimbursement.

A. Part 'A' UB-92 Provider Bills

- **INPATIENT HOSPITAL:** Calculated according to the PA WC DRG (Diagnostic Related Group) reimbursement formula referenced in the Bureau's user manual (**Tables A and B**)
 - Note: when re-pricing out-of-state inpatient bills, the provider number for Harrisburg Hospital 99994 is to be utilized.

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- **COST-BASED PROVIDERS (OUTPATIENT HOSPITALS AND PHYSICAL THERAPY):** Each cost-based provider has a unique Medicare Provider # and a unique set of service codes in the PA WC Charge master. If a service code is not in the Charge master, it is to be disallowed, utilizing the reason code “Denied as not properly billed; service code is not listed in providers PA WC Charge master.” If a provider’s service code is listed in the Charge master with a \$0 allowance, it must be reimbursed at 80% of billed charges or the billed fee multiplied by the provider’s RCC (cost to charge ratio).
- **SKILLED NURSING FACILITIES:** These facilities can be identified by a provider number which starts with 39-5####. Skilled Nursing facilities are reimbursed at a daily treatment rate that should be accessed from Table C. There are two different fees to access for each provider. One for services provided in-house (Inpatient column) and one for services provided outside the facility (Outpatient column).
- **HOME HEALTH CARE AGENCIES:** These facilities can be identified by a provider number which starts with 39-7####. Home Health Care Agencies care reimbursed at a daily treatment rate that is accessed from Table D.
- **AMBULATORY SURGICAL CENTERS:** Payments to providers of outpatient surgery in an Ambulatory Surgery Center (ASC) are based on the ASC payment groups defined by HCFA. These providers are to be reimbursed using Tables E, F, and EF-1. ASCs are classified based on CPT codes into one of eight groups. Each group has a payment rate assigned to it. The payment rate represents an all-inclusive payment to the provider for service performed.
- **COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFs):** There are currently only 16 providers in PA that this applies to. They are all reimbursed at a daily treatment rate that should be accessed from Table G.
- **PHARMACY RCC TABLE:** Refer to Table H. This table is used in conjunction with the PA Charge master and is used to re-price all Revenue Codes 250-259. This table allows for the accurate re-pricing of pharmacy charges billed by cost-based providers.
- **DME AND LABORATORY CHARGES:** Revenue codes 290-299 (DME) and 300-309 (laboratory) are re-priced using the Part B fee schedule.
- **TRAUMA:** Acute care provided in a trauma center or a burn facility is exempt from the medical fee caps and shall be paid based on 100% of the usual and customary charges. Since the PA WC Bureau does not recognize any type of U&C fee schedule, this amounts to 100% of charges. The care

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must meet the guidelines set forth in Section (F1) (10) and 127.128E and F of the WC Act.

- Patient must have an immediately life-threatening or urgent injury that meets the PA EMS Regional guidelines that include (1) mechanism of injury, (2) level of consciousness, (3) types of injuries, (4) co-morbid factors (heart disease, obesity, etc.).
- Acute care treatment must be performed in a Level I or II trauma center accredited by the PA Trauma Systems Foundation.
- Burn facilities must meet all the service standards of the American Burn Association.
- Basic and advanced life support services, as defined and licensed under the Emergency Medical Services (WMS) Act, must be utilized.
- The re-pricing exemptions apply, and continue for the full course of treatment when the patient is transferred from one trauma center to another.

B. Part B HCFA Provider Bills

- **PHYSICIAN EXAMINATIONS:** New and established patients. Documentation is required to support a particular level of coding. (99201-99215 and 99241-99245).
 - New patient: Has not received any professional services from the physician or another member of the group in the same specialty within the past 3 years.
 - Established: Has received professional services within the past 3 years.
 - On-call: Where the physician is covering for another physician. The patient encounter is classified as it would have been by the physician who is not available.
 - **SECTION 127.105(d) (e):** The PA EX regulation requires HCPCS codes 99201-99215 to be billed using modifier “-25” (indicating a significant, separately identifiable E/M service by the same physician on the same day of procedure).
 - **NOTE:** Examinations performed by physician assistants and nurse practitioners (PA, PAC, and CRNP) are reimbursed at 85% of the fee schedule.
- **BUNDLING/UNBUNDLING:** Section 127.204 Fragmenting or unbundling of charges by providers. A provider may not fragment or unbundle charges except as consistent with Medicare utilizing National Correct Coding Edits.

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- **Unbundling:** The billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code.
- **Two types of coding combinations:** Comprehensive and mutually exclusive
- **MULTIPLE SURGERY/INJECTIONS:** Multiple surgeries/injections are separate procedures performed by physicians on the same patient at the same operative session or on the same day.
 - **Reimbursement:** 100% of the WC Allowance for the highest valued procedure; 50% of the WC Allowance for the remaining procedures.
- **ASSISTANCE AT SURGERY:** A physician or non-physician practitioner who actively assists when a physician performs a surgical procedure listed on the eligible assistance at surgery codes section (Appendix I of the Medicare Part B Reference Manual). Operative Report must support that the assistance did enough to qualify for payment.
 - **Modifiers:**
 - **80 or 82:** Physician acting as the Assistant at Surgery
 - **AS:** Non-physician practitioner acting as the Assistant at Surgery (PA or CRNP)
 - **Reimbursement**
 - **80 or 82:** 16% of the WC Fee Schedule
 - **AS:** 16% x 85% of the WC Fee Schedule
 - **Note:** Multiple Surgery Reimbursement Rates apply to this methodology of reimbursement as well.
- **CO-SURGERY:** A single surgical procedure that requires the skill of two surgeons, usually with different skills, of the same or different specialties performing parts of the same procedure simultaneously. Procedure must be listed on the list of co-surgery codes (Chapter 22, pages 22-11 through 22-16 of the Medicare Part B Reference Manual).
 - **Modifier:** Each physician would report the surgical procedure with a “62” modifier.
 - **Reimbursement:** 62.5% of the WC Fee Schedule.
 - **Note:** Multiple Surgery Reimbursement Rules apply to this methodology of reimbursement as well.
- **GLOBAL PACKAGE (PERIOD):** The global surgical package includes a standard package of pre-operative, intra-operative, and post-operative services as follows:

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- **Major Surgery:** 90 days post-op, 1 day pre-op
- **Minor Surgery:** 10 days post-op, no pre-op
- **Endoscopic:** no post or pre-op

- **ANESTHESIA:** Services involving the administration of anesthesia. Must be performed by an anesthesiologist or CRNA and the anesthesia report must be attached to the provider's bill. CPT codes 00100-01999.
 - **Base Units:** Relative units assigned to the anesthesia procedure. This gives a "basic value" for the service
 - **Time Units:** One time unit = 15 minutes (unit numbers are rounded to the nearest tenth)
 - **Modifiers/Conversion Factors:**
 - **AA, AD, QZ:** 100% Conversion Factor
 - **QK, QX, QY, QS:** 50% Conversion Factor
 - **Calculations:** Base units + Time units x Conversion Factor = Reimbursement

- **DOWNCODING:** When the insurer changes a billed code or modifier to another billed code or modifier that results in a lower monetary reimbursement. Refer to Section 127.207 of the Act and the Bureau's outline on down-coding regulations and requirements.

- **PHYSICAL THERAPY SERVICES:**
 - Use of therapy evaluations (97001-97004): Clinical judgments are made based on gathered data.
 - Codes may be separately reported if, and only if, patient's condition requires significant, separately identifiable E/M service above and beyond the usual pre-, intra-, and post service associated with the procedure performed.
 - Modality Codes: Common question regarding these codes involves the intended number of times these services may be reported. Both supervised and modality and constant attendance codes include language in the descriptor that indicates "application of a modality to one or more areas."
 - Supervised modalities (97010-97028): Time is not a factor in determining the use of supervised modalities, and therefore is

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intended to be used only once during an encounter regardless of the number of areas.

- Constant attendance modality codes (97032-97039): Include a time component “each 15 minutes.” Codes are reported once for each 15 minutes of service provided. If less than 15 minutes of service provided, then reduced service modifier ‘52’ is appended to the code to identify reduction of service.
 - Manual Therapy Techniques (“hands-on”) Code 97140: Mobilization, manipulation, manual lymphatic drainage, and manual traction are examples of procedures that may be reported with the code and not intended to exclude other types of manual therapy. Code 97140 is to be reported for each 15 minutes.
 - Codes 97140-59–98940: There are times when it is appropriate to additionally report either Chiropractic or Osteopathic Manipulative Treatment Codes in addition to manual therapy code 97140. Provider would have to append -59 modifier and identify a separate body area.
 - Manual Therapy Techniques (“hands on”): 97140 one or more regions each 15 minutes, including but not limited to:
 - Connective tissue massage
 - Joint immobilization/manipulation
 - Manual lymphatic drainage
 - Manual traction
 - Passive range of motion
 - Soft tissue mobilization/manipulation
 - Therapeutic massage
- **DURABLE MEDICAL EQUIPMENT (DME):** Providers must add one of the following modifiers to accurately re-price DME. They are NU (New), UE (Used) and RR (Rented).
- **Rental** is reimbursed at 10% of purchase price per month. If no Medicare mechanism for reimbursement exists, the reimbursement may not exceed 10% of the actual purchase price.
 - Rental may be paid up to a maximum of 13 months or until purchase price has been met. The item is then considered “purchased” as used (UE).
 - Supplies, instructions and repairs are not reimbursed during the rental period.
- **MODIFIERS 26 & TC:** The “26” is utilized for the professional component (reading). “TC” refers to the technical component (taking of the diagnostic test). There is a separate allowable in the Part B fee schedule for providers performing both, in which case no modifier is used. Therefore, there are 3 fees

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listed in the fee table, one for the total component (w/o a modifier), one for the "26", and one for the "TC." This is important, as the reimbursements are drastically different.

- **OUT-OF-STATE PROVIDERS:** Section 127.129 (b) notes that out-of-state providers who are not licensed by the Commonwealth are subject to the fee caps set forth in Harrisburg. Meaning, they use zip code 17104 (Harrisburg) to access the correct locality.
- **SITE OF SERVICE FEE SCHEDULE:** This refers to a medical provider performing exams, surgical procedures, or any other service at a facility other than their own private office. There are many providers who fall into this category, specifically surgeons and emergency room physicians. Any time the provider bill (HCFA) has a 21,22,23,24,26,31,34,41,51,53,56 or 61 in block 24(b) of the HCFA, the site of service fee should be applied. For many CPT codes in the Part B diskette, there are separate site of service fees which are much lower than standard fees. The reasoning is that the payer is already paying the hospital for using its facility.
- **PRESCRIPTIONS:** Are reimbursed at 110% of the Average Wholesale Price (AWP). In order to be reimbursed, providers must include the National Drug Code (NDC) number, description of medication, strength, and caplet/tablets dispensed.