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

<table>
<thead>
<tr>
<th>Zipcode</th>
<th>Charge Classes</th>
<th>Zipcode</th>
<th>Charge Classes</th>
<th>Zipcode</th>
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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:

<table>
<thead>
<tr>
<th>PART A TABLES</th>
<th>PART B</th>
</tr>
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<tbody>
<tr>
<td>HTML</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Provider #389001 to #390501</td>
<td>DSG #1 to #200</td>
</tr>
<tr>
<td>Provider #385441 to #395441</td>
<td>DSG #201 to #400</td>
</tr>
<tr>
<td>Provider #385422 to #395422</td>
<td>DSG #401 to #499</td>
</tr>
<tr>
<td>Provider #387500 to #387500</td>
<td>DSG #501 to #599</td>
</tr>
</tbody>
</table>

| D             | E      |
| Provider #387601 to #387601 | Provider #387451 to #387451 |
| Provider #387401 to #387401 | Provider #387551 to #387551 |
| Provider #387671 to #387671 | Provider #387751 to #387751 |

| F             | G      |
| Ambulatory Surgical Providers | Physical Therapy Fee Based Provider |
| Pharmacy RCC |        |

<table>
<thead>
<tr>
<th>Excel</th>
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<th>F.S.</th>
<th>123</th>
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</table>

2
The CPT code information is accessed by clicking the hyperlink range that contains code 99204: \textit{97018-99347}.

Scroll down to code 99204:

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Modifier</th>
<th>Medicare Location</th>
<th>Global Surgery Indicator</th>
<th>Multiple Surgery Indicator</th>
<th>Prevailing Charge Amount</th>
<th>Fee Schedule Amount</th>
<th>Site of Service Amount</th>
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</thead>
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<td>0</td>
<td>14137</td>
<td>12033</td>
<td></td>
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</tbody>
</table>

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
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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- 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
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.