NC WORKERS' COMPENSATION:

BASIC INFORMATION FOR

MEDICAL PROVIDERS

CURRENT AS OF APRIL 1, 2010

I. INFORMATION SOURCES

Where is information available for medical providers treating patients with injuries/conditions that may be the subject of a workers' compensation claim?

The North Carolina Industrial Commission website. The Industrial Commission is the state agency responsible for administering the Workers' Compensation Act.

http://www.ic.nc.gov

The **Workers' Compensation Act** is contained within Chapter 97 of the North Carolina General Statutes and is available at:

http://www.ncleg.net/enactedlegislation/statutes/pdf/bychapter/chapter_97.pdf

The Industrial Commission has promulgated **Workers' Compensation Rules** in accordance with the Workers' Compensation Act which are available at:

http://www.ic.nc.gov/ncic/pages/comprule.htm

The **NCIC Medical Fee Schedule** which governs reimbursement amounts for medical treatment is available at:

http://www.ic.nc.gov/medfeeschdisclaimer.html

The **NCIC Rating Guide** which provides guidelines for evaluating permanent partial impairment is available at:

http://www.ic.nc.gov/ncic/pages/ratinggd.htm

II. ISSUES AND RULES REGARDING REIMBURSEMENT ELIGIBILITY

How can a medical provider verify workers' compensation coverage and the responsible party for payment for treatment related to an employee's on the job injuries?

Contact the self-insured employer, workers' compensation carrier or administrator and obtain written authorization for treatment.

How can a medical provider determine an employer's workers' compensation carrier?

The workers' compensation insurance carrier for an employer may be identified by visiting the Commission's website at http://www.comp.state.nc.us/iwcnss/

Who provides and directs the injured employee's medical treatment?

The employer/carrier/administrator, subject to any Commission orders, provides and directs medical treatment. The Commission may permit the employee to change physicians or approve a physician of employee's selection when good grounds are shown. However, payment by the employer/carrier/administrator is not guaranteed unless written permission to change physicians is obtained from the employer/carrier/administrator, or Commission before the treatment is rendered. N.C.G.S. §97-25

Any employer/carrier/administrator denying a claim in which medical care has previously been authorized shall be responsible for all costs incurred prior to the date notice of denial is provided to each health care provider to whom authorization has been previously given. NCIC Workers' Compensation Rule 407(7)

Why should the employee ALWAYS file a first report of injury to the North Carolina Industrial Commission?

The employee should always file a Form 18, "Notice of Accident to Employer and Claim of Employee, Representative, or Dependent for Workers' Compensation Benefits," even though the employer may be paying compensation without an agreement or the Commission may have opened a file on the claim pursuant to the employer/carrier/administrator filing a Form 19 to ensure that the Industrial Commission has jurisdiction of all issues regarding an employee's claim, including medical bill payment. N.C.G.S. § 97-22 and 97-24

A "medical only" claim occurs when an injured employee incurs no more than one day of lost time, no disfigurement or impairment, and no more than $2000.00 in medical expenses. The North Carolina Industrial Commission does not require the employer/carrier/administrator to submit a Form 19, "Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission," for these claims, so there is no Industrial Commission file number created. NCIC Workers' Compensation Rule 104

Sometimes the Medical Fee Section is able to work out small issues on "medical only"claims. As the employer is not required by law to file a Form 19 for "medical only" claims, an employee must file a Form 18 in order to preserve jurisdiction of any disputes regarding "medical only" claims.

How can a medical provider determine if the North Carolina Industrial Commission has jurisdiction of a workers' compensation case?

The medical provider should submit an inquiry note or letter (on company letterhead) with proof of the bill attached to the Medical Fees Section. This inquiry may be faxed to (919) 715-0282. If the medical provider has questions about this process, they may contact the Medical Fees Section at (919) 807-2503.

New and/or Revised Forms and New Medical Motion Procedures

On April 1, 2008, all Employer/Carrier/Administrators received the following notice in the Form 18 Acknowledgment letter: "ATTENTION EMPLOYER/CARRIER/ADMINISTRATOR: Within 30 days after receipt of the Form 18, you must file a Form 21, 60, 61, or 63 to admit, deny or pay without prejudice. The failure to comply with this requirement will subject you to sanctions."

New or Revised Forms

In compliance with N.C. Gen. Stat. §97-78, effective August 1, 2008, the Industrial Commission adopted new and/or revised Forms 18, 19, 25R, 26, 26A, 60, and 63 (all revised 8/6/08) through Minutes. Please click here for a summary of instructions regarding related policies and procedures and here for complete instructions.

III. MEDICAL BILLING ISSUES & RULES

Do HIPAA regulations change the procedure of sending medical records with the workers' compensation bill?

No, HIPAA law does not preempt state law on workers' compensation and should not impede the billing process.

> "§164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required. (l) Standard: disclosures for workers' compensation. A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."

What reimbursement amount will a medical provider receive for treatment of workers' compensation patients?

A medical provider's reimbursement is limited to the maximum amount approved in the NCIC Medical Fee Schedule, unless the provider has contracted with the insurer for a different amount. If neither the fee schedule nor a contractual fee applies, the maximum reimbursement allowed is the usual, customary, and reasonable charge for the service. N.C.G.S. §97-26(c)

Where should a medical provider send the bill for payment?

The bill along with the medical records should be sent to the employer/carrier/administrator, not the Industrial Commission.

How long does a medical provider have to submit a bill to the payer?

A provider of medical compensation shall submit its statement for services within 75 days of the rendition of the service or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided, or within such other reasonable period of time as allowed by the Industrial Commission. However, in cases where liability is initially denied but subsequently admitted or determined by the Industrial Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. NCIC Workers' Compensation Rule 407(2)

Within 30 days of receipt of the statement, the employer, or carrier, or managed care organization, or administrator on its behalf, shall pay or submit the statement to the Industrial Commission for approval or send the provider written objections to the statement. If an employer, carrier/administrator or managed care organization disputes a portion of the provider's bill, it shall pay the uncontested portion of the bill and shall resolve disputes

regarding the balance of the charges through its contractual arrangement or through the Industrial Commission. NCIC Workers' Compensation Rule 407(2)

What information must the medical provider include on the UB 92 or CMS 1500 forms submitted to the payer?

See the chart herein for appropriate field locations for the UB 92 and CMS 1500 forms. The box numbers on the CMS 1500 and UB 92 correspond to the numbers in this list.

When submitting medical bills, the provider must include:

1. Entity's name
2. Entity's tax ID
3. Employee's (patient's) name
4. Employee's (patient's) phone number
5. Employee's (patient's) social security number or ID number
6. Patient account number as assigned by the provider
7. Employer's name
8. Carrier/payer name
9. Date of injury
10. Date(s) of service per line item
11. Procedure codes per line item
12. Diagnosis codes
13. Admission date
14. Discharge date
15. Billed charges per procedure code
16. Medical notes or operative report
17. Phone number and name of provider representative, position, or department designated to receive notice when claim is denied

When submitting medical bills, to expedite claims processing, the provider should include, if available:

18. IC number
19. Carrier claim number
20. Authorization code

What information must the payer include on its explanation of payment sent to a medical provider?

When the carrier or other payer is submitting payment to a provider, the payer must provide:

1. Entity name
2. Entity tax ID
3. Employee's (patient's) name
4. Employee's social security number
5. Employer's name

6. Patient account number
7. Date of injury
8. Date(s) of service per line item
9. Procedure code(s) by line item
10. Amount charged and amount paid for each procedure code (data fields should include Workers' Compensation Fee Schedule reductions, PPO discounts or other contract reductions, adjustments, and non-covered charges. Charges that are denied should be identified along with reason for denial or non-payment)
11. Language required by NCIC (including dispute resolution, contact information, and late payment penalty rules)
12. Carrier's name, address, and contact information (including telephone number and the name or title of the appropriate individual or position to contact regarding the claim)
13. Where applicable, PPO's name, address, and contact information (including telephone number and the name of the appropriate individual or position to contact regarding the claim)
14. Explanation of Payment with the check

When submitting payment, the payer should include, if available:

15. Carrier claim number
16. IC number
17. Authorization Code

Please see form locator chart on next page for appropriate location of each item on HCFA 1500 (CMS 1500) and UB92.

Provider Billing Requirements & Payer Payment Requirements

		Provider Billing Requirements		Payer Payment Requirements	
	Data Element	Hospital UB92 (form locator)	Physician HCFA 1500 (form locator)	EOB[2] for Hospital Services	EOB[2] for Physician Services
1	Entity Name	1	33	Yes	Yes
2	Entity Tax ID	5	33	Yes	Yes
3	Employee/Patient Name	12	2	Yes	Yes
4	Employee/Patient Phone Number	n/a--no designated box	5	No	No
5	Employee/Patient SS#/Patient ID#	60	1a	Yes	Yes
6	Employee/Patient Account Number as assigned by Provider	3	26	Yes (Account # or Medical Record #)	Yes (Account # or Medical Record #)
7	Employer Name	65	4	Yes--Payer (No--Employer)	Yes--Payer/Yes--Employer
8	Carrier/Payer Name	50	11C	Yes	Yes
9	Date of Injury	32 (or 33,34,35,36)	14	Yes	Yes
10	Dates of service per line item	45 (outpatient treatment only, none for inpatient)	24A	Yes (from and to dates)	Yes (from and to dates)
11	Procedure Codes per line item Outpatient (HCPCS/CPT) Inpatient (ICD-9)	 44 80, 81 (a-e)	24D	Yes	Yes
12	Diagnosis Codes (ICD-9/CPT)	67 thru 77	21, 24E	Yes	Yes
13	Admission Date	6	24A	Yes	Yes
14	Discharge Date	6	24A	Yes	Yes
15	Billed charges per procedure code	47	24F	Yes	Yes
16	Medical Notes/Operative Report	n/a--no designated box	n/a--no designated box	No	No
17	Contact Information	84	19	No	No
18	IC Number	If available, use 56	if available, use 10d	Yes	Yes
19	Carrier Claim Number (Ins. Grp. No.)	If available, use 62	If available, use 11	Yes	Yes
20	Authorization Code	63	23	No	No
21	Payment per procedure code	n/a	n/a	Yes	Yes
22	Adjustments per procedure code	n/a	n/a	Yes	Yes
23	Total Paid	n/a	n/a	Yes[1]	Yes[1]
24	Total Adjustment	n/a	n/a	Yes	Yes

[1] Payment voucher must be attached to EOB when sent to provider.

[2] EOB must have "workers comp" noted on form somewhere

How long does a payer have to reimburse a medical provider for authorized treatment?

Payments of "clean claims" (where liability has been admitted and the proper information as stated above is provided on or with the claim) shall be paid in accordance with N.C.G.S. §97-18(i) and Rule 407. **If a clean claim is not paid within 60 days** after it has been approved by the Commission and returned to the responsible party, or within 60 days after it was properly submitted to an insurer or managed care organization responsible for direct reimbursement, **the Industrial Commission will automatically assess an amount equal to ten (10) percent of the unpaid medical bill** unless such late payment is excused by the Commission.

The Industrial Commission may enforce compliance by random audits of all payers.

Complaints and requests for penalty orders should be directed to the chief medical fee examiner at the following address:

Chief Medical Fee Examiner
NC Industrial Commission
Medical Billing Section
4337 Mail Service Center
Raleigh, NC 27699-4337
919.807.2614
bernadine.singh@ic.nc.gov

How may medical providers resolve disputes with payers regarding reimbursement amounts?

The medical provider should first attempt to resolve billing disputes directly with the payer. Unresolved disputes should be submitted to the North Carolina Industrial Commission Medical Fees Section with a carbon copy to the payer. Submitted information should include the following:

1. Cover letter explaining dispute
2. Copies of bill
3. Copies of medical reports related to dispute
4. Copy of the payer's previous explanation of payment
5. Any additional documentation felt to be related to issue

Per N.C.G.S. §97-26(i), the employee or health care provider may also apply to the Commission by motion or for a hearing to resolve **any** dispute regarding the payment of charges for medical compensation.

Per NCIC Workers' Compensation Rule 407, medical providers may appeal the fee schedule amount and request higher reimbursement in special hardship cases where sufficient reason is demonstrated to the Industrial Commission that fees in excess of those so published should be allowed. The medical provider may exercise his right to request hearing to address hardship issues as described in the preceding paragraph per N.C.G.S. §97-26(i).

A copy of all documents filed with the Industrial Commission regarding any billing dispute should be sent to all other parties.

May a medical provider ever directly bill a patient for medical services related to an alleged workers' compensation claim?

N.C.G.S. §97-90(e) governs this issue and states:

> *"A health care provider shall not pursue a private claim against an employee for all or part of the costs of medical treatment provided to the employee by the provider unless the employee's claim or the treatment is finally adjudicated not to be compensable or the employee fails to request a hearing after denial of liability by the employer."*

N.C.G.S. §97-88.3(c) establishes penalties for medical providers who improperly pursue private claims against employees:

> *"A health care provider who knowingly charges or otherwise holds an employee financially responsible for the cost of any services provided for a compensable injury under this Article is guilty of a Class 1 misdemeanor."*

If a claim is denied by the workers' compensation payer and the injured worker appeals to the Commission, the provider must wait until the Commission's decides on the compensability of the patient's claim and medical bills. If the Commission agrees that the claim and/or medical treatment are not compensable, then the provider may bill the injured worker.

Employers/carriers are responsible for paying for authorized services up to the point of the denial of the claim. NCIC Workers' Compensation Rule 407(7)

What laws exist regarding workers' compensation medical billing and treatment fraud?

Medical providers treating workers' compensation patients must also abide by the following laws regarding fraud.

N.C.G.S. §97-88.3. Penalty for health care providers.

> *(a) In addition to any liability under G.S. 97-88.2, any health care provider who willfully or intentionally undertakes the following acts is subject to an administrative penalty, assessed by the Commission, not to exceed ten thousand dollars ($10,000):*
>
> 1. *Submitting charges for health care that was not furnished;*
> 2. *Fraudulently administering, providing, and attempting to collect for inappropriate or unnecessary treatment or services; or*
> 3. *Violating [state laws pertaining to self-referrals].*
>
> *A penalty assessed by the Commission for a violation of subdivision (3) of this subsection is in addition to penalties assessed under G.S. 90-407.*

(b) In addition to any liability under G.S. 97-88.2, any health care provider who willfully or intentionally undertakes the following acts is subject to an administrative penalty, assessed by the Commission, not to exceed one thousand dollars ($1,000):

1. *Failing or refusing to timely file required reports or records;*
2. *Making unnecessary referrals; and*
3. *Knowingly violating this Article or rules promulgated hereunder, including treatment guidelines, with intention to deceive or to gain improper advantage of a patient, employee, insurer, or the Commission.*

(c) A health care provider who knowingly charges or otherwise holds an employee financially responsible for the cost of any services provided for a compensable injury under this Article is guilty of a Class 1 misdemeanor.

(d) Any person, including, but not limited to, an employer, an insurer, and an employee of an insurer, who in good faith comes forward with information under this section, shall not be liable in a civil action.

(e) Information relating to possible violations under this section shall be reported to the Commission which shall refer the same to the appropriate licensing or regulatory board or authority for the health care provider involved.

(f) A hospital that relies in good faith on a written order of a physician in performing health care services shall not be subject to an administrative penalty in violation of this section.

What should occur when a medical provider's claim is denied by the payer?

When liability for payment of compensation is denied initially or subsequent to a payment without prejudice, the proper party (i.e. insurance carrier, third party administrator, or self-insured employer), within 14 days of receipt of the claim, shall provide a copy of the Form 61 denial to the Commission, to the claimant, to the claimant's attorney (if any), and to all known health care providers. To ensure that health care providers are made aware of denials, the health care provider must designate an individual, position, or department within its facility or practice to receive the Form 61 for workers' compensation cases. This designation shall be identified on the original medical bill.

All other denials of payment for medical treatment to an authorized medical provider may be appealed to the Medical Billing Section or a hearing may be requested per N.C.G.S. §97-26.1.

What should occur when a medical provider's bill is received by the payer?

Workers' compensation payers must respond to all medical bills. For each medical bill received for which no first report of injury has been issued, the payer must follow up by telephone with the employer to verify the existence of a workers' compensation claim. If no claim is verified, the medical bill shall be returned to the medical provider with a letter stating that no claim exists. This letter shall be signed by the carrier representative and shall include the

representative's phone number. This letter shall be copied to the employer and the patient so the patient can file a Form 18 if he/she feels that an injury has occurred.

What should occur when a denial of payment is received by the provider because no workers' compensation claim exists?

When a claim is denied because the payer has no report of injury (Form 18 or Form 19), the medical provider should send a copy of the bill and the denial (which shall include the reason for the denial) to the employer and patient and direct the patient to the Industrial Commission website for information on filing a workers' compensation claim. The medical provider may then bill the patient or employer as appropriate.

What about workers' compensation medical treatment involving a PPO?

The employer/carrier/insurer/administrator that contracts with a PPO or any third party for the payment or processing of medical bills shall ensure that such PPO or third party complies with the IC's procedures. Ultimate responsibility for compliance rests with the employer/carrier/insurer/administrator that contracts with the PPO or applicable third party.

IV. NC INDUSTRIAL COMMISSION MEDICAL FEE SCHEDULE

What reimbursement amount will a medical provider receive for treatment of workers' compensation patients?

A medical provider's reimbursement is limited to the maximum amount approved in the NCIC Medical Fee Schedule, unless the provider has contracted with the insurer for a different amount. If neither the fee schedule nor a contractual fee applies, the maximum reimbursement allowed is the usual, customary, and reasonable charge for the service. N.C.G.S. §97-26(c)

How are medical providers reimbursed for new procedures or CPT codes NOT included in the NCIC Medical Fee Schedule?

If reimbursement has **not** been set by the Industrial Commission, these services should be paid by agreement between the medical provider and payer.

How much are medical providers reimbursed for supplies?

The North Carolina Industrial Commission has adopted nearly 1100 HCPCS billing codes to describe supplies and equipment used in workers' compensation treatment. However, the Commission has not yet incorporated into its fee schedule all of the HCPCS level codes for supplies and equipments. For example, none of the "J" codes have been adopted. If a supply is billed, and the code does not have a fee assigned in the Commission schedule, the provider is entitled to 20% above invoice cost.

The Commission will allow a provider to use CPT code 99070 when billing for supplies or equipment that are not designated in the Workers' Compensation Medical Fee Schedule. The provider is entitled to cost plus 20%.

If a custom-made orthotic or prosthetic is not contained in the Commission schedule, these items should be paid per agreement between provider and payer.

Are there special requirements to be reimbursed for consultation codes?

Yes, check AMA and other coding guides, but it is essential that the consultative physician report findings back to the requesting party or physician. When the treating physician transfers the complete care to another physician the Commission considers this a referral and not a consultation. Then, the new physician should bill a new patient visit.

V. MEDICAL RECORDS CONTENT

Information to be included in Progress Reports per NCIC Medical Fee Schedule Section 16

1. Date of most recent examination.
2. Present condition and progress since last report.
3. Measurements of function.
4. X-ray or laboratory report since last examination.
5. Treatment—type, duration.
6. Work status—patient working or estimated date of return to work.
7. Permanent impairment to be anticipated.

Information to be included in Reports of Special Examinations per NCIC Medical Fee Schedule Section 16

The following information is essential and should be incorporated in written reports:

1. History of case as obtained from you from the injured (note any pre-existing injuries or diseases).
2. Injured's symptoms and complaints as obtained by you.
3. Physical findings (this is to include laboratory, x-ray, etc.). Include measurements of function according to accepted standard of the American Medical Association Guides.
4. Diagnosis of condition or conditions found.
5. Your opinion as to the relation between condition or conditions diagnosed and the injured's alleged injury or occupational exposure, with your reasons for your opinion.
6. Whether any temporary disability exists; if so, whether it is total or partial, and its probable duration.
7. What physical impairment, if any, can be expected.
8. Where permanent disability has resulted and the case is ready for permanent disability rating, the extent of impairment should be given in detail. Where measurements can be taken and can be related to the corresponding opposite measurement, both

measurements should be given as a fraction of injured over uninjured. If both sides are involved in the injury, then any estimate of the normal measurement should be given. If a part of the disability is attributable to a prior injury or disability, the extent to which the present impairment is affected by the prior condition must be given and may be expressed as a percentage; i.e., 50% of impairment due to injury; 50% due to preexisting factors.

9. What treatment, if any, is indicated, including type, frequency, and probable duration.

10. Any other medical information that you believe pertinent to the case, to assist in making an equitable adjustment.

11. Give date patient in your opinion should be able to return to work or actual date of return if known.

What form is used for reporting the injured employee's permanent partial impairment rating?

Form 25R, Evaluation for Permanent Impairment

VI. RELEASE OF MEDICAL RECORDS

May a medical provider charge for providing copies of an injured employee's medical records in a workers' compensation case?

The Industrial Commission has set a reasonable fee for searching, handling, copying, and mailing of medical records as follows pursuant to N.C.G.S. § 97-26.1.

> *No more than 50 cents per page for the first 40 pages and 20 cents per page for each page above 40, subject to a minimum fee of $10. Such fee covers searching handling, copying and mailing.*

Medical providers must provide one free copy of medical records to the first requesting party among the following entities considered defendant representatives in each case: employers, insurance carriers, third party administrators, and rehabilitation nurses. Medical providers may charge the above stated fee for providing medical records to each subsequent requesting defendant representative listed in the preceding sentence.

Medical providers may always charge the above fee for providing medical records to the employee or the employee's attorney or other plaintiff representatives.

Who is entitled to receive a patient's medical records related to their workers' compensation claim?

The provisions of N.C.G.S. §97-25.6 describe when an employer or insurer may communicate with a medical provider as follows:

1. Any employer or insurer paying medical compensation to a provider rendering treatment may obtain records of the treatment without authorization of or notice to the employee.

2. An employer or insurer may, with written notice to the employee, obtain directly from a medical provider medical records restricted to a current injury or condition for which the employee is claiming compensation. This request does not require the authorization of the employee but does require that the employee receive notice of the request.

3. Upon written request from the employer or insurer, the employee or their attorney shall provide medical records or reports in their possession restricted to conditions related to the injury or illness for which the employee is seeking compensation.

4. An employer or insurer paying compensation for an admitted claim or paying compensation without prejudice may communicate with an employee's medical provider in writing limited to the attached questions adopted by the North Carolina Industrial Commission.

Other forms of communication with a medical provider may be authorized by:

(i) a valid written authorization voluntarily given and signed by the employee;
(ii) by agreement of the parties;

(iii) by Order of the Commission issued upon a showing that the information sought is necessary for the administration of the employee's claim and is not otherwise reasonably obtainable under N.C. Gen. Stat. §97-25.6 or through other provisions for discovery authorized by the Commission's Rules.

What is the "Workers' Compensation Medical Status Questionnaire" and how is it used?

Here is the link to the Industrial Commission webpage that includes the following explanation and a downloadable copy of the questionnaire on the next page.

http://www.ic.nc.gov/ncic/pages/wcmsques.pdf

Workers' Compensation Medical Status Questionnaire

Instructions

• The attached questionnaire, which has been approved by the North Carolina Industrial Commission, may be submitted by an employer/insurer paying compensation for an admitted workers' compensation claim to medical providers who have treated an employee for a work-related injury or condition.

• Medical providers are authorized by N.C.G.S. 97-25.6 to respond to these questions without an authorization from the employee.

• The medical provider may respond in any of the following ways:
1. By providing appropriate responses on the attached questionnaire;
2. By including appropriate responses in the medical notes; or
3. By including appropriate responses in a letter.

• Medical providers need only respond to questions that are checked by the employer on the attached questionnaire.

• Medical providers are not required to answer questions for which they do not have sufficient information to formulate an opinion.

• Medical providers may charge, and the requesting employer/insurer shall pay, a reasonable fee not to exceed the current fee established under the NCIC fee schedule for CPT code 99080.

• Responses shall be provided to the employer or its insurer (or their designated agents or representatives, including the assigned rehabilitation professional), and to the employee or his/her representative simultaneously.

Medical Provider Work or Job Status Forms
Medical providers may continue the practice of providing Work or Job Status Forms to the employee and the employer/insurer or assigned rehabilitation professional after each visit or when appropriate. This may be done without the express authorization of the employee.