



STATE OF MICHIGAN
JOCELYN BENSON, SECRETARY OF STATE
DEPARTMENT OF STATE
LANSING

June 4, 2025

NOTICE OF FILING

ADMINISTRATIVE RULES

To: Secretary of the Senate
Clerk of the House of Representatives
Joint Committee on Administrative Rules
Michigan Office of Administrative Hearings and Rules (Administrative Rule #24-022-LE)
Legislative Service Bureau (Secretary of State Filing #25-06-01)
Department of Labor and Economic Opportunity

In accordance with the requirements of Section 46 of Act No. 306 of the Public Acts of 1969, being MCL 24.246, and paragraph 16 of Executive Order 1995-6, this is to advise you that the Michigan Office of Administrative Hearings and Rules filed Administrative Rule #2024-022-LE (Secretary of State Filing #25-06-01) on this date at 10:40 A.M. for the Department of Labor and Economic Opportunity entitled, "Workers' Compensation Health Care Services".

These rules become effective immediately upon filing with the Secretary of State unless adopted under section 33, 44, or 45a(9) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the Secretary of State.

Sincerely,

Jocelyn Benson
Secretary of State


Lashana Threlkeld, Departmental Supervisor
Office of the Great Seal

Enclosure



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 4, 2025

The Honorable Jocelyn Benson
Secretary of State
Office of the Great Seal
Richard H. Austin Building – 1st Floor
430 W. Allegan
Lansing, MI 48909

Dear Secretary Benson:

Re: Michigan Administrative Rules #: 2024-22 LE

The Michigan Office of Administrative Hearings and Rules received administrative rules, dated January 31, 2025 for the Department of Labor and Economic Opportunity **“Workers' Compensation Health Care Services”**. We are transmitting these rules to you pursuant to the requirements of Section 46 of Act No. 306 of the Public Acts of 1969, being MCL 24.246, and paragraph 16 of Executive Order 1995-6.

Sincerely,

Michigan Office of Administrative Hearings and Rules



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

LEGAL CERTIFICATION OF RULES

I certify that I have examined the attached administrative rules, dated January 31, 2025, in which the Department of Labor and Economic Opportunity proposes to modify a portion of the Michigan Administrative Code entitled "Workers' Compensation Health Care Services" by:


- ◆ Amending R 418.10106, R 418.10107, R 418.10205, R 418.10404, R 418.10901, R 418.10904, R 418.10915, R 418.10920, R 418.101002, and R 418.101004.
- ◆ Rescinding R 418.10201 and R 418.10206.

The Legislative Service Bureau has approved the proposed rules as to form, classification, and arrangement.

I approve the rules as to legality pursuant to the Administrative Procedures Act, MCL 24.201 *et seq.* and Executive Order No. 2019-6. In certifying the rules as to legality, I have determined that they are within the scope of the authority of the agency, do not violate constitutional rights, and are in conformity with the requirements of the Administrative Procedures Act.

Dated: March 24, 2025

Michigan Office of Administrative Hearings and Rules

By: 
Ashlee N. Lynn,
Attorney



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY
LANSING

SUSAN CORBIN
DIRECTOR

CERTIFICATE OF ADOPTION

2024-22 LE

WORKERS' DISABILITY COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

Pursuant to the authority conferred on the Department of Labor and Economic Opportunity, and the authority conferred on the director of the workers' disability compensation agency by sections 205 and 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.205 and 418.315, section 33 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, and Executive Reorganization Order Nos. 1982-2, 1986-3, 1990-1, 1996-2, 2003-1, 2011-4, and 2019-13, MCL 18.24, 418.1, 418.2, 445.2001, 445.2011, 445.2030, and 125.1998).

R 418.10106, R 418.10107, R 418.10205, R 418.10404, R 418.10901, R 418.10904, R 418.10915, R 418.10920, R 418.101002, and R 418.101004 of the Michigan Administrative Code are amended, and R 418.10201 and R 418.10206 are rescinded.

Date: 3/25/2025

Adopted by: Susan R. Corbin
Susan R. Corbin, Director

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Since 1941

Legal Division

Timothy H. Shields, Director

CERTIFICATE OF APPROVAL

On behalf of the Legislative Service Bureau, and as required by section 45 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.245, I have examined the proposed rules of the Department of Labor and Economic Opportunity dated January 31, 2025, amending R 418.10106, R 418.10107, R 418.10205, R 418.10404, R 418.10901, R 418.10904, R 418.10915, R 418.10920, R 418.101002, and R 418.101004, and rescinding R 418.10201 and R 418.10206 of the Department's rules entitled "Workers' Compensation Health Care Services." I approve the rules as to form, classification, and arrangement.

Dated: March 24, 2025

LEGISLATIVE SERVICE BUREAU

By _____

Rachel M. Hughart,
Legal Counsel

DEPARTMENT OF LABOR AND ECONOMIC OPPORTUNITY

WORKERS' DISABILITY COMPENSATION AGENCY

WORKERS' COMPENSATION HEALTH CARE SERVICES

Filed with the secretary of state on June 4, 2025

These rules become effective immediately after filing with the secretary of state unless adopted under section 33, 44, or 45a(9) of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, 24.244, or 24.245a. Rules adopted under these sections become effective 7 days after filing with the secretary of state.

(By authority conferred on the workers' disability compensation agency by sections 205 and 315 of the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.205 and 418.315, section 33 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.233, and Executive Reorganization Order Nos. 1982-2, 1986-3, 1990-1, 1996-2, 2003-1, 2011-4, and 2019-3, MCL 18.24, 418.1, 418.2, 445.2001, 445.2011, 445.2030, and 125.1998)

R 418.10106, R 418.10107, R 418.10205, R 418.10404, R 418.10901, R 418.10904, R 418.10915, R 418.10920, R 418.101002, and R 418.101004 of the Michigan Administrative Code are amended, and R 418.10201 and R 418.10206 are rescinded, as follows:

R 418.10106 Procedure codes; relative value units; other billing information.

Rule 106. (1) Upon annual promulgation of R 418.10107, the health care services division of the agency shall provide separate from these rules a manual, tables, and charts containing all of the following information on the agency's website, www.michigan.gov/leo/bureaus-agencies/wdca:

(a) All Current Procedural Terminology (CPT®) procedure codes used for billing healthcare services.

(b) Medicine, surgery, and radiology procedures and associated relative value units.

(c) Hospital maximum payment ratios.

(d) Billing forms and instruction for completion.

(2) The procedure codes and standard billing and coding instructions for medicine, surgery, and radiology services are adopted from the most recent publication titled "Current Procedural Terminology (CPT®)," as adopted by reference in R 418.10107. However, billing and coding guidelines published in the CPT codebook do not guarantee reimbursement. A carrier shall only reimburse medical procedures for a work-related injury or illness that are reasonable and necessary and are consistent with accepted medical standards.

(3) The formula and methodology for determining the relative value units is adopted from the "RBRVS DataManager Online" as adopted by reference in R 418.10107, using geographical information for this state. The geographical information, (GPCI), is a melded average using 60%

of the figures published for the city of Detroit, added to 40% of the figures published for the rest of this state.

(4) The maximum allowable payment for medicine, surgery, and radiology services is determined by multiplying the relative value unit assigned to the procedure by the conversion factor listed in the reimbursement section, part 10, of these rules.

(5) Procedure codes from "HCPCS 2025 Level II Professional Edition," as adopted by reference in R 418.10107, must be used to describe all the following services:

- (a) Ambulance services.
- (b) Medical and surgical expendable supplies.
- (c) Dental procedures.
- (d) Durable medical equipment.
- (e) Vision and hearing services.
- (f) Home health services.

(6) Medical services are considered by report if a procedure code listed in "HCPCS 2025 Level II Professional Edition" or "Current Procedural Terminology (CPT®) 2025 Professional Edition," as adopted by reference in R 418.10107, does not have an assigned value.

R 418.10107 Source documents; adoption by reference.

Rule 107. The following documents are adopted by reference in these rules and are available for distribution from the indicated sources, at the cost listed in subdivisions (a) to (h) of this rule:

(a) "Current Procedural Terminology (CPT®) 2025 Professional Edition," published by the American Medical Association, 330 North Wabash Avenue, Suite 39300, Chicago, Illinois 60611-5885, item #EP054125, 1-800-621-8335. The publication may be purchased through the AMA's website at www.amastore.com. The list price is \$137.89 at the time of adoption of these rules. Permission to use this publication is on file in the agency.

(b) "HCPCS 2025 Level II Professional Edition," published by the American Medical Association, 330 North Wabash Avenue, Suite 39300, Chicago, Illinois 60611-5885, item #OP231525, customer service 1-800-621-8335. The publication may be purchased through the AMA's website at www.amastore.com. The list price is \$110.16 at the time of adoption of these rules.

(c) "RBRVS DataManager Online," published by The American Medical Association, 330 North Wabash Avenue, Suite 39300, Chicago, Illinois 60611-5885, 1-800-621-8335. The publication may be purchased through the AMA's website at www.amastore.com. The list price is \$320.00 at the time of adoption of these rules.

(d) "International Classification of Diseases, ICD-10-CM 2025: The Complete Official Codebook," American Medical Association, 330 North Wabash Avenue, Suite 39300, Chicago, Illinois 60611-5885, item #OP201425, 1-800-621-8335. The publication may be purchased through the AMA's website at www.amastore.com. The list price is \$118.60 at the time of adoption of these rules.

(e) "International Classification of Diseases, ICD-10-PCS 2025: The Complete Official Codebook," American Medical Association, 330 North Wabash Avenue, Suite 39300, Chicago, Illinois 60611-5885, item #OP201125, 1-800-621-8335. The publication may be purchased through the AMA's website at www.amastore.com. The list price is \$118.60 at the time of adoption of these rules.

(f) Merative™ Micromedex® Red Book® online subscription service of Merative, which can be purchased at <https://www.merative.com/contact> or from Merative, 100 Phoenix Drive, Ann Arbor, Michigan 48108, 1-844-637-2848.

(g) Medi-Span® Drug Information Database, a part of Wolters Kluwer Health, which can be purchased from <https://www.wolterskluwer.com/en/solutions/medi-span> or 1-855-633-0577.

(h) "Official UB-04 Data Specifications Manual 2025, July 1, 2024" adopted by the National Uniform Billing Committee, Copyright 2024 American Hospital Association. As of the time of adoption of these rules, the cost of this eBook for a single user is \$179.00 and is available at www.nubc.org.

R 418.10201 Rescinded.

R 418.10205 Consultation services.

Rule 205. (1) An attending physician, carrier, third-party administrator, or the injured worker may request a consultation. Procedure codes 99242 to 99245 and 99252 to 99255 must not be used for consultation examinations. Providers shall use the evaluation code that most accurately reflects the service rendered.

(2) If a specialist performs diagnostic procedures or testing in addition to the evaluation, the specialist shall bill the appropriate procedure code from the CPT® codebook. The carrier shall reimburse the testing procedures in accordance with these rules.

R 418.10206 Rescinded.

R 418.10404 Follow-up care occurring during global service.

Rule 404. (1) Follow-up care for a diagnostic procedure must refer only to the days required to recover from the diagnostic procedure and not the treatment of the underlying condition.

(2) Follow-up care for therapeutic surgical procedures includes only that care that is usually part of the surgical service. Complications, exacerbations, recurrence, or the presence of other compensable diseases or injuries requiring additional services must be reported with the identification of appropriate procedures. The follow-up days for the surgical procedures are adopted from the "RBRVS DataManager Online" as referenced in R 418.10107. The follow-up days for each surgical procedure are provided separate from these rules on the agency's website, <https://www.michigan.gov/leo/bureaus-agencies/wdca>. All of the following apply to the global service provider:

(a) If a carrier requests the surgeon to see an injured worker during the global service period for the purpose of job restrictions, job adjustments, or return to work, the visit is not considered part of the global surgery package. If the carrier requests the visit, the carrier shall prior authorize the visit by assigning an authorization number. The provider shall bill the visit using procedure code 99455 and modifier -32, including the authorization number in box 23 of the CMS 1500 claim form. The carrier shall not deny a prior authorized visit and shall reimburse the provider for the prior authorized visit. The maximum allowable payment for procedure code 99455-32 must be listed in the manual published separate from these rules.

(b) The medical record must reflect job adjustments, job restrictions or limitations, or return to work date, and the provider shall include the medical record with the bill.

(c) If an insured employer requests the surgeon to see an injured worker during the global surgery period for the purpose of job adjustments, restrictions, or return to work, the employer shall obtain the prior authorization number from the carrier for the visit.

(3) Hospital follow-up care or a hospital visit by the practitioner responsible for the surgery is considered part of the surgical follow-up days listed for the procedure and is not paid as an independent procedure.

R 418.10901 General information.

Rule 901. (1) All health care practitioners and health care organizations, as defined in these rules, shall submit charges on the proper claim form as specified in this rule. Copies of the claim forms and instructions for completion for each form must be provided separate from these rules in a manual on the agency's website at <https://www.michigan.gov/leo/bureaus-agencies/wdca>. Charges must be submitted as follows:

(a) A practitioner shall submit charges on the CMS1500 claim form.

(b) A doctor of dentistry shall submit charges on a standard dental claim form approved by the American Dental Association.

(c) A pharmacy, other than an inpatient hospital, shall submit charges on an invoice or an NCPDP workers compensation/property & casualty universal claim form.

(d) A hospital-owned occupational or industrial clinic, or office practice shall submit charges on the CMS 1500 claim form.

(e) A hospital billing for a practitioner service shall submit charges on a CMS 1500 claim form.

(f) Ancillary service charges must be submitted on the CMS 1500 claim form for durable medical equipment and supplies, L-code procedures, ambulance, vision, and hearing services. Charges for home health services must be submitted on the UB-04 claim form.

(g) A shoe supplier or wig supplier shall submit charges on an invoice.

(2) A provider shall submit all bills to the carrier within 1 year after the date of service for consideration of payment, except in cases of litigation or subrogation.

(3) A properly submitted bill must include all the following appropriate documentation:

(a) A copy of the medical report for the initial visit.

(b) An updated progress report if treatment exceeds 60 days.

(c) A copy of the initial evaluation and a progress report every 30 days of physical treatment, physical or occupational therapy, or manipulation services.

(d) A copy of the operative report or office report if billing surgical procedure codes 10004-69990.

(e) A copy of the anesthesia record if billing anesthesia codes 00100 to 01999.

(f) A copy of the radiology report if submitting a bill for a radiology service accompanied by modifier -26. The carrier shall only reimburse the radiologist for the written report, or professional component, on receipt of a bill for the radiology procedure.

(g) A report describing the service if submitting a bill for a by report procedure.

(h) A copy of the medical report if a modifier is applied to a procedure code to explain unusual billing circumstances.

(4) A health care professional billing for telemedicine services shall utilize procedure codes 97161 to 97168, or those listed in Appendix P of the CPT® codebook, as adopted by reference in R 418.10107, excluding CPT® codes 99242 to 99245 and 99252 to 99255. The provider shall append modifier -95 to the procedure code to indicate synchronous telemedicine services rendered

via a real-time interactive audio and video telecommunications system with place of service code -02 or -10. All other applicable modifiers must be appended in addition to modifier -95.

R 418.10904 Procedure codes and modifiers.

Rule 904. (1) A healthcare service must be billed with procedure codes adopted from "Current Procedural Terminology (CPT®) 2025 Professional Edition" or "HCPCS 2025 Level II Professional Edition," as referenced in R 418.10107. Procedure codes from the CPT® code set are not included in these rules but are provided on the agency's website at www.michigan.gov/leo/bureaus-agencies/wdca. Refer to "Current Procedural Terminology (CPT®) 2025 Professional Edition," as referenced in R 418.10107, for standard billing instructions, except where otherwise noted in these rules. A provider billing services described with procedure codes from "HCPCS 2025 Level II Professional Edition" shall refer to the publication as adopted by reference in R 418.10107, for coding information.

(2) The following ancillary service providers shall bill codes from "HCPCS 2025 Level II Professional Edition," as adopted by reference in R 418.10107, to describe the ancillary services:

- (a) Ambulance providers.
- (b) Certified orthotists and prosthetists.
- (c) Medical suppliers, including expendable and durable equipment.
- (d) Hearing aid vendors and suppliers of prosthetic eye equipment.
- (e) A home health agency.

(3) If a practitioner performs a procedure that cannot be described by 1 of the codes listed in the most recent publication titled "Current Procedural Terminology (CPT®)" or "HCPCS Level II," as adopted in R 418.10107, the practitioner shall bill the unlisted procedure code. An unlisted procedure code must only be reimbursed when the service cannot be properly described with a listed code and the documentation supporting medical necessity includes all the following:

- (a) Description of the service.
- (b) Documentation of the time, effort, and equipment necessary to provide the care.
- (c) Complexity of symptoms.
- (d) Pertinent physical findings.
- (e) Diagnosis.
- (f) Treatment plan.

(4) The provider shall add a modifier code, found in Appendix A of the CPT® codebook, as adopted by reference in R 418.10107, following the correct procedure code describing unusual circumstances arising in the treatment of a covered injury or illness. When a modifier code is applied to describe a procedure, a report describing the unusual circumstances must be included with the charges submitted to the carrier.

(5) Applicable modifiers from table 10904 must be added to the procedure code to describe the type of practitioner performing the service. The required modifier codes for describing the practitioner are as follows:

Table 10904 Modifier Codes

- (a) AA: When anesthesia services are performed personally by the anesthesiologist.
- (b) AD: When an anesthesiologist provides medical supervision for more than 4 qualified individuals, being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.
- (c) AH: When a licensed psychologist bills a diagnostic service or a therapeutic service, or both.

- (d) AJ: When a certified social worker bills a therapeutic service.
- (e) AL: When a limited license psychologist bills a diagnostic service or a therapeutic service.
- (f) CO: When occupational therapy services are furnished in whole or in part by an occupational therapy assistant.
- (g) CQ: When physical therapy services are furnished in whole or in part by a physical therapy assistant.
- (h) CS: When a limited licensed counselor bills for a therapeutic service.
- (i) GF: When a non-physician, such as a nurse practitioner, advanced practice nurse, or physician assistant, provides services.
- (j) LC: When a licensed professional counselor performs a therapeutic service.
- (k) MF: When a licensed marriage and family therapist performs a therapeutic service.
- (l) ML: When a limited licensed marriage and family therapist performs a service.
- (m) TC: When billing for the technical component of a radiology service.
- (n) QK: When an anesthesiologist provides medical direction for not more than 4 qualified individuals, being either certified registered nurse anesthetists, certified anesthesiologist assistants, or anesthesiology residents.
- (o) QX: When a certified registered nurse anesthetist or certified anesthesiologist assistant performs a service under the medical direction of an anesthesiologist.
- (p) QZ: When a certified registered nurse anesthetist performs anesthesia services without medical direction.

R 418.10915 Billing for anesthesia services.

Rule 915. (1) Anesthesia services must consist of 2 components, base units and time units. Each anesthesia procedure code is assigned a value for reporting the base units. The base units for an anesthesia procedure must be as specified in the publication titled "RBRVS DataManager Online" as adopted by reference in R 418.10107. The anesthesia codes, base units, and instructions for billing the anesthesia service must be provided separate from these rules on the agency's website, <https://www.michigan.gov/leo/bureaus-agencies/wdca>.

(2) When billing for both the anesthesiologist and a certified registered nurse anesthetist or a certified anesthesiologist assistant, the anesthesia procedure code must be listed on 2 lines of the CMS 1500 claim form with the appropriate modifier on each line.

(3) One of the following modifiers must be added to the anesthesia procedure code to determine the appropriate payment for the time units:

- (a) Modifier -AA indicates the anesthesia service is administered by the anesthesiologist.
- (b) Modifier -QK indicates the anesthesiologist has provided medical direction for not more than 4 qualified individuals being a certified registered nurse anesthetist (CRNA), certified anesthesiologist assistant (AA), or resident. The CRNA, AA, or resident may be employed by a hospital, the anesthesiologist, or self-employed.
- (c) Modifier -AD indicates an anesthesiologist has provided medical supervision for more than 4 qualified individuals being either a certified registered nurse anesthetist, certified anesthesiologist assistant, or anesthesiology resident.
- (d) Modifier -QX indicates the certified registered nurse anesthetist or certified anesthesiologist assistant has administered the procedure under the medical direction of the anesthesiologist.
- (e) Modifier -QZ indicates the certified registered nurse anesthetist has administered the complete anesthesia service without medical direction of an anesthesiologist.

(4) Total anesthesia units are calculated by adding the anesthesia base units to the anesthesia time units.

(5) Anesthesia services may be administered by any of the following:

- (a) A licensed doctor of dental surgery.
- (b) A licensed doctor of medicine.
- (c) A licensed doctor of osteopathy.
- (d) A licensed doctor of podiatry.
- (e) A certified registered nurse anesthetist.
- (f) A licensed anesthesiology resident.
- (g) A certified anesthesiologist assistant.

(6) If a surgeon provides the anesthesia service, the surgeon shall only be reimbursed the base units for the anesthesia procedure.

(7) If a provider bills physical status modifiers, the documentation must be included with the bill to support the additional risk factors. When billed, the physical status modifiers are assigned unit values as defined in table 10915, as follows:

Table 10915 Anesthesiology Physical Status Modifiers Unit Value

P1: A normal healthy patient = 0

P2: A patient who has a mild systemic disease = 0

P3: A patient who has a severe systemic disease = 1

P4: A patient who has a severe systemic disease that is a constant threat to life = 2

P5: A moribund patient who is expected not to survive without the operation = 3

P6: A declared brain-dead patient whose organs are being removed for donor purposes = 0

(8) Procedure code 99140 must be billed as an add-on procedure if an emergency condition, as defined in R 418.10108, complicates anesthesia. Procedure code 99140 must be assigned 2 anesthesia units. Documentation supporting the emergency must be attached to the bill.

(9) If a pre-anesthesia evaluation is performed and surgery is not subsequently performed, the service must be reported as an evaluation and management service.

R 418.10920 Billing for supplementary radiology supplies.

Rule 920. (1) For radiology procedures involving the use of contrast, contrast material must be billed utilizing procedure codes in the "HCPCS Level II Professional Edition," as adopted by reference in R 418.10107. The provider shall include an invoice documenting the wholesale price of the contrast material used and the provider shall be reimbursed the wholesale price of the contrast material.

(2) Contrast materials are only separately payable in an ASC if allowed separate payment under the OPPS, which is provided separate from these rules on the agency's website, <https://www.michigan.gov/leo/bureaus-agencies/wdca>.

R 418.101002 Conversion factors for practitioner services.

Rule 1002. (1) The agency shall determine the conversion factors for medicine, evaluation and management, physical medicine, surgery, pathology, and radiology procedures. The conversion factor is used by the agency for determining the maximum allowable payment for medical,

surgical, and radiology procedures. The maximum allowable payment is determined by multiplying the appropriate conversion factor by the relative value unit assigned to a procedure. The relative value units are provided for the medicine, surgical, and radiology procedure codes separate from these rules on the agency's website, www.michigan.gov/leo/bureaus-agencies/wdca. The relative value units are updated by the agency using codes adopted from "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107. The agency shall determine the relative values by using information found in the "RBRVS DataManager Online" as adopted by reference in R 418.10107.

(2) The conversion factor for medicine, radiology, and surgical procedures is \$49.08 for the year 2025 and is effective for dates of service on or after the effective date of these rules.

R 418.101004 Modifier code reimbursement.

Rule 1004. (1) Modifiers may be used to report that the service or procedure performed was altered by a specific circumstance but does not change the definition of the code. This rule lists procedures for reimbursement when certain modifiers are used. A complete listing of modifiers is listed in Appendix A of "Current Procedural Terminology CPT® 2025 Professional Edition," and the "HCPCS 2025 Level II Professional Edition" as adopted by reference in R 418.10107.

(2) When modifier code -25 is added to an evaluation and management procedure code, reimbursement must only be made when the documentation provided supports that the patient's condition required a significant separately identifiable evaluation and management service, other than the other service provided or beyond the usual preoperative and postoperative care.

(3) When modifier code -26, professional component, is used with a procedure, the professional component must be paid.

(4) If a surgeon uses modifier code -47 when performing a surgical procedure, anesthesia services that were provided by the surgeon and the maximum allowable payment for the anesthesia portion of the service is calculated by multiplying the base unit of the appropriate anesthesia code by \$42.00. No additional payment is allowed for time units.

(5) When modifier code -50 or -51 is used with surgical procedure codes, the services must be paid according to the following, as applicable:

(a) The primary procedure at not more than 100% of the maximum allowable payment or the billed charge, whichever is less.

(b) The secondary procedure and the remaining procedure or procedures at not more than 50% of the maximum allowable payment or the billed charge, whichever is less.

(c) When multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body must be reimbursed 100% of the maximum allowable payment or billed charge, whichever is less, and the second and remaining surgical procedure or procedures must be identified by modifier code -51 and be reimbursed at 50% of the maximum allowable payment or billed charges, whichever is less.

(d) When modifier -50 or -51 is used with a surgical procedure with a maximum allowable payment of by report, the maximum allowable payment must be 50% of the provider's usual and customary charge or 50% of the reasonable amount, whichever is less.

(6) The multiple procedure payment reduction must be applied to the technical and professional component for more than 1 radiological imaging procedure furnished to the same patient, on the same day, in the same session, by the same physician or group practice. When modifier -51 is used with specified diagnostic radiological imaging procedures, the payment for the technical

component of the procedure must be reduced by 50% of the maximum allowable payment and payment for the professional component of the procedure must be reduced to 75% of the maximum allowable payment. A table of the diagnostic imaging CPT® procedure codes subject to the multiple procedure payment reduction are provided by the agency in a manual separate from these rules.

(7) When modifier code -TC, technical services, is used to identify the technical component of a radiology procedure, payment must be made for the technical component only. The maximum allowable payment for the technical portion of the radiology procedure is designated on the agency's website, www.michigan.gov/leo/bureaus-agencies/wdca.

(8) When modifier -57, initial decision to perform surgery, is added to an evaluation and management procedure code, the modifier -57 indicates an evaluation and management service resulted in the initial decision to perform surgery, either the day before or the day of a major surgery, and is not part of the global surgical service.

(9) When both surgeons use modifier -62 and the procedure has a maximum allowable payment, the maximum allowable payment for the procedure must be multiplied by 25%. Each surgeon is paid 50% of the maximum allowable payment multiplied by 25%, or 62.5% of the maximum allowable payment. If the maximum allowable payment for the procedure is by report, the reasonable amount must be multiplied by 25% and be divided equally between the surgeons.

(10) When modifier code -80 is used with a procedure, the maximum allowable payment for the procedure must be 20% of the maximum allowable payment listed in these rules, or the billed charge, whichever is less. If a maximum payment has not been established and the procedure is by report, payment must be 20% of the reasonable payment amount paid for the primary procedure.

(11) When modifier code -81 is used with a procedure code that has a maximum allowable payment, the maximum allowable payment for the procedure must be 13% of the maximum allowable payment listed in these rules or the billed charge, whichever is less. If modifier code -81 is used with a by report procedure, the maximum allowable payment for the procedure must be 13% of the reasonable amount paid for the primary procedure.

(12) When modifier -82 is used and the assistant surgeon is a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine, or a doctor of dental surgery, the maximum level of reimbursement is the same as modifier -80. If the assistant surgeon is a physician's assistant, the maximum level of reimbursement is the same as modifier -81. If an individual other than a physician or a certified physician's assistant bills using modifier -82, the charge and payment for the service is reflected in the facility fee.

(13) When modifier -GF is billed with evaluation and management or minor surgical services, the carrier shall reimburse the procedure at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less.

(14) When modifier -95 is used with procedure code 97161 to 97168, or those listed in Appendix P of the CPT® codebook, as adopted by reference in R 418.10107, excluding CPT® codes 99242 to 99245 and 99252 to 99255, the telemedicine services are reimbursed according to all of the following:

(a) The carrier shall reimburse the procedure code at the non-facility maximum allowable payment, or the billed charge, whichever is less.

(b) Supplies and costs for the telemedicine data collection, storage, or transmission must not be unbundled and reimbursed separately.

(c) Originating site facility fees must not be separately reimbursed.

(15) Modifier -CO must be appended to a procedure code if the procedure was furnished entirely by the occupational therapy assistant (OTA), or if the OTA has provided a portion of a procedure, separately from the part that is furnished by the occupational therapist, exceeding 10% of the total time for the procedure code. When modifier -CO is used, the procedure code must be reimbursed at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less. Modifier -CO and the corresponding 15% reduction is not applicable if the occupational therapist has provided more than half of the timed procedure code without the minutes provided by the OTA.

(16) Modifier -CQ must be appended to a procedure if the procedure was furnished entirely by the physical therapy assistant (PTA), or if the PTA has provided a portion of a procedure, separately from the part that is furnished by the physical therapist, exceeding 10% of the total time for the procedure code. When modifier -CQ is used, the procedure code must be reimbursed at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less. Modifier -CQ and the corresponding 15% reduction is not applicable if the physical therapist has provided more than half of the timed procedure code without the minutes provided by the PTA.

FILED WITH SECRET

DATE

ON 6-4-25 10:40 AM