Workers Compensation
California Billing Guidelines

Helmsman Management Services LLC®

Liberty Mutual. INSURANCE

Liberty Mutual Insurance and Helmsman Management Services expect physicians and clinics to use appropriate and up-to-date billing practices (e.g., use of coding based on services provided). Detailed information is available on our website at www.libertymutualprovidersupport.com.

For in-network practitioners, reimbursement rates are determined by the network contract, so any concerns should be addressed with the network's contracting team. For out-of-network practitioners, reimbursement rates are determined by the fee schedule. Practitioners should not ask individual Claims staff to make additional payments, nor stipulate to a reimbursement rate, outside of the guidelines outlined below.

We acknowledge that there may be times when Liberty/Helmsman asks a practitioner for additional workup that is not covered by the fee schedule, or where the billing codes may be unclear. To ensure fairness and consistency, we will pay for those services as follows.

If a surgery, injection, or other procedure has been authorized but lacks a corresponding fee schedule code and/or rate:

- For in-network practitioners, any concerns around reimbursement rates should be addressed with the network's contracting team. Practitioners should not ask individual Claims staff to negotiate, as they are not in a position to do so. Anthem can be reached via telephone at (866) 700-2168 or email at MPNServices@wellpoint.com.
- For out-of-network practitioners, reimbursement rates would typically be calculated based on Usual and Customary (U&C) rates.

If Liberty/Helmsman asks a practitioner to review records:

- We strive to make this process as efficient as possible. When a case involves a detailed history, the adjuster or Nurse Case Manager should prepare a brief summary so that a practitioner can quickly and succinctly understand what is going on. Practitioners are welcome to review more detailed records if necessary, but by summarizing the case upfront, we strive to keep time-consuming reviews to a minimum.
- For dates of service on or after March 1, 2017, record reviews should be billed using California's Official Medical Fee Schedule (OMFS) using codes 99358 and/or 99359 as appropriate.

If a Nurse Case Manager, vocational expert, or any other Liberty/Helmsman representative asks to meet with the practitioner:

- In most cases, the Nurse Case Manager or other representative will attend the patient's appointment. In this situation, there should be no need for additional workup on the practitioner's part, so no additional codes should be billed.
- In some cases, the Nurse Case Manager or other representative may need to set a separate appointment to meet with the practitioner. In this situation, the appointment should be billed just like any other follow-up visit; no pre-payment is offered. (For example, if the Nurse Case Manager or vocational expert sets a 15-minute appointment, it should be billed just like any other 15-minute follow-up visit.)

If a Utilization Review (UR) issue comes up, including a peer reviewer asking to speak with the practitioner, or a practitioner who wishes to appeal a UR denial:

- We strive to make these discussions as concise and helpful as possible. We encourage practitioners to submit clear and well-documented Requests for Authorization (RFAs) in compliance with the Medical Treatment Utilization Schedule (MTUS) so that delays and disputes are kept to a minimum.
    - When an RFA is sent to a peer reviewer, the reviewer will have a discussion with the ordering physician or designee whenever possible. These discussions are designed to prevent any undue delay in care, service or treatment. California law does require that decisions be made within tight timeframes, so if ordering physicians or designees are unavailable, the peer reviewer may need to make a decision based solely on the records submitted.
    - An internal appeal process is available when a denial has been rendered. This internal appeal is optional and unrelated to the state's Independent Medical Review (IMR). If a practitioner chooses to pursue this appeal, we encourage the ordering physician to specifically address the reasons for the peer reviewer's determination, including the clinical reasons regarding medical necessity and the relevant medical criteria or guidelines used to reach the decision.
- Under California's Official Medical Fee Schedule (OMFS), most physician consultations are no longer payable. Therefore, practitioners should not bill for these discussions unless an extenuating circumstance exists, as defined below.
    - If an ordering physician needs to spend more than ten minutes discussing a case with a peer reviewer, practitioners should bill under code T1017. We will pay $60.00 for every 15 minutes spent.
    - If an ordering physician needs to spend more than ten minutes preparing an internal appeal, practitioners should bill under code T1017. We will pay $60.00 for every 15 minutes spent, provided it follows the above-listed guidelines and does not correct the ordering physician's own errors and/or simply reiterate the same information previously available.

If Liberty Mutual asks a practitioner to clarify a patient's Permanent and Stationary (P&S) report, including a Permanent Disability rating under the AMA Guides:

- Treating physicians should bill these reports under code WC004. We will pay the fee schedule and/or contract rate for that code.
- Agreed Medical Examiners (AME's) and Qualified Medical Examiners (QME's) should bill these reports under the appropriate code in the medical-legal fee schedule. We will pay according to the fee schedule rate for that code.