*Workers’ Comp*

**Get Your Workers’ Comp Claims Paid With These Expert Tips**

*BONUS: 5 Handy Checklists Make Workers’ Comp a Breeze!*

Handling workers’ compensation billing doesn’t have to be a pain, says Trish Bukauskas, a coding and billing expert who recently presented (https://www.audioeducator.com/multi-speciality-coding-training/workers-compensation-medical-billing.html ) for AudioEducator.

And workers’ comp claims don’t have to saddle your RCM cycle with extra A/R days either. You can get them reimbursed within one week of filing—if you know the ropes.

**Sweat the Details**

Workers’ comp claims typically require a high level of precision, and even small mistakes can result in denials. To start out right, research ahead of time what the requirements and guidelines are, and go from there. You’ll typically need:

* claimant name,
* claimant case number,
* CPT**®** or HCPCS code(s),
* ICD-10 code,
* the requested date of service,
* appropriate supporting documentation,
* the provider name, and
* provider number/ID

**Prior Authorization Checklist**

Wondering about prior authorization? You need if you are billing for:

* Durable medical equipment and medical supplies – send a copy of the original order, but providers are not required to furnish a product invoice and providers must use proper HCPCS of A9999 if unlisted
* Biofeedback
* EMG/NCS services
* Physical medicine (PT and OT)
* Manipulative treatment
* Chiropractic treatment
* Pain management

Factors that will **sink** a prior authorization request include:

* The case is closed
* Claimant can’t be found
* Injury date is missing for a claimant with multiple cases
* The service requested in unclear
* Any of the following are missing: prescription (if required), rental or purchase price (if required), and frequency and duration.

**Caution:** “They want the authorization form to be exact,” Bukaukas says. “If we put ‘four weeks’ and [the patient’s] verbiage says ‘one month,’ the federal Department of Labor says [the claim] can be denied for that.”

**Steer Clear of These 14 Denials Triggers**

Some reasons for workers’ comp denials are similar to what causes other payers to deny non-workers’ comp claims. They include:

1. Claimant is ineligible
2. Disagreements with accepted condition
3. No authorization
4. Improper CPT code(s)
5. Improper ICD 10 code(s)
6. Claimant ID or tax ID are missing
7. Incorrect provider number
8. No physician signature on file
9. The provider is not enrolled
10. The patient reached maximum medical improvement
11. Service is not considered “medically necessary”
12. Service is not related to the condition
13. There is no active, open claim on file
14. The claim wasn’t filed on time.

**CPT® Reference Tool for Workers’ Comp Claims**

There are several services unique to workers comp that are worth keeping in mind, Bukaukas says.

* CPT**®** 99456 CN – failing to keep an appointment
* CPT**®** 99455 – impairment rating
* CPT**®** 99456 – independent medical exam
* CPT**®** 99457 – independent medical exam, consensus
* CPT**®** 99750 – functional capacity evaluation
* CPT**®** 99020 – narrative report or special reports, such as insurance forms
* CPT**®** 99075 – medical testimony

[Sidebar #1]

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**Revealed: Common CMS-1500 Form Mistakes That Cause Denials.**

The devil is always in the details, and when it comes to workers’ comp, it’s often problems with the CMS-1500 form that cause denials, says Trish Bukauskas, a coding and billing expert who recently presented (https://www.audioeducator.com/multi-speciality-coding-training/workers-compensation-medical-billing.html ) for AudioEducator.

Note: The CMS-1500 often goes by its older name—the HCFA-1500 form. No matter what you like to call it, attention to this checklist will ensure that your workers’ comp claims are paid.

* Make sure that you include signature on file in **boxes 12 and 13** on CMS-1500. **Note:** The date in box 12 must be the same as the date in box 24.
* **Box 21:** If the claim spans the time period covering the switch from ICD-9 to ICD-10, you need two separate forms—one for ICD-9 and another for ICD-10.
* **Box 31** needs the signature of the treating provider and the bill date must be after last date of service.
* **Box 33** is the most important of them all—it’s the billing address.

**Tip:** Save yourself a headache and lots of paper—file electronically and use direct deposit. Not only does this cut paper work and speed the entire process, but it simplifies things when doing follow up since everything you need is stored online.

[End Sidebar #1]

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