

(5) Ground ambulance services are considered reasonable when a medical condition is such that use of other forms of transportation are contraindicated and would endanger the patient's health.

(6) A properly submitted air or ground ambulance bill shall include documentation indicating the necessity of air or ground ambulance services.

(7) An air ambulance service shall be covered only to the nearest facility capable of furnishing the required level and type of care for the injury or illness involved.

(8) The ambulance point of pick up shall be reported by its 5-digit ZIP code. Charges for services and mileage shall be based on documented loaded patient mileage only. If the patient is pronounced dead by a legally authorized professional after the air ambulance has taken off or the ground ambulance is dispatched, but before being loaded onto the ambulance for transport, then the MAP is the appropriate base rate, with no amount allowed for mileage or for a rural adjustment.

(9) Ambulance origin and destination modifiers listed in the HCPCS Level II codebook, as adopted by reference in R 418.10107, shall be used on the bill as appropriate and will be listed on the agency website at www.michigan.gov/wca.

(10) All items and services associated with the ambulance transport are included in the maximum allowable payment and shall not be unbundled and billed separately.

(11) Ground ambulance services are reimbursed based on the level of services performed, not the type of vehicle responding.

PART 10. REIMBURSEMENT SUBPART A. PRACTITIONER REIMBURSEMENT

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 shall be used by the agency for determining the maximum allowable payment for medical, surgical, and radiology procedures. The maximum allowable payment shall be determined by multiplying the appropriate conversion factor times 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/wca. The relative value units shall be updated by the agency using codes adopted from "Current Procedural Terminology (CPT®)" as adopted by reference in R 418.10107(a). The agency shall determine the relative values by using information found in the "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107(c).

(2) The conversion factor for medicine, radiology, and surgical procedures shall be \$47.66 for the year 2021 and shall be effective for dates of service on or after the effective date of these rules.

R 418.101003 Reimbursement for "by report" and ancillary procedures.

Rule 1003. (1) If a procedure code does not have a listed relative value, or is noted BR, then the carrier shall reimburse the provider's usual and customary charge or reasonable payment, whichever is less, unless otherwise specified in these rules.

(2) The following ancillary services are by report and the provider shall be reimbursed either at the practitioner's usual and customary charge or reasonable payment, whichever is less:

- (a) Dental services.
- (b) Vision and prosthetic optical services.
- (c) Hearing aid services.
- (d) Home health services.

(3) Orthotic and prosthetic procedures, L0000-L9999, shall be reimbursed by the carrier at Medicare plus 5%. The health care services division shall provide maximum allowable payments for L-code procedures separate from these rules on the agency's website, www.michigan.gov/wca. Orthotic and prosthetic procedures with no assigned maximum allowable payment shall be considered by report procedures and require a written description accompanying the charges on the CMS-1500 claim form. The report shall include date of service, a description of the service or services provided, the time involved, and the charge for materials and components.

R 418.101003a Reimbursement for dispensed medications.

Rule 1003a. (1) Prescription medication shall be reimbursed at the average wholesale price (AWP) minus 10%, as determined by Red Book or Medi-Span referenced in R 418.10107, plus a dispense fee. All of the following apply.

- (a) The dispense fee for a brand name drug shall be \$3.50 and shall be billed with WC700-B.
 - (b) The dispense fee for a generic drug shall be \$5.50 and shall be billed with WC700-G.
 - (c) Reimbursement for repackaged pharmaceuticals shall be at a maximum reimbursement of AWP minus 10% based upon the original manufacturer's NDC number, as published by Red Book or Medi-Span, plus a dispensing fee of \$3.50 for brand name and \$5.50 for generic.
 - (d) All pharmaceutical bills submitted for repackaged products shall include the original manufacturer or distributor stock package national drug code or NDC number.
 - (e) When an original manufacturer's NDC number is not available in either Red Book or Medi-Span and a pharmaceutical is billed using an unlisted or "not otherwise specified code," the payer shall select the most closely related NDC number to use for reimbursement of the pharmaceutical.
- (2) Over-the-counter drugs (OTC's), dispensed by a provider other than a pharmacy, shall be dispensed in 10-day quantities and shall be reimbursed at the average wholesale price, as determined by Red Book or Medi-Span or \$2.50, whichever is greater.
- (3) All commercially manufactured topical medications, that do not meet the definition of "custom compound" as defined in R 418.10108, dispensed by a pharmacy or a provider shall not exceed a 30-day supply. Regardless of dispensing party, reimbursement shall be at a maximum of the acquisition cost, plus a single dispense fee. The single dispense fee