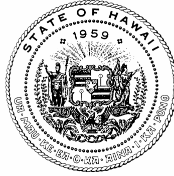
LINDA LINGLE
GOVERNOR



NELSON B. BEFITEL
DIRECTOR

COLLEEN Y. LaCLAIR
DEPUTY DIRECTOR

GARY S. HAMADA
ADMINISTRATOR

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION

830 PUNCHBOWL STREET, ROOM 209
P.O. BOX 3769
HONOLULU, HAWAII 96812-3769
www.hawaii.gov/labor
Phone: (808) 586-9151 / Fax: (808) 586-9219

August 8, 2006

TO: Hawaii Workers' Compensation Community and Interested Stakeholders

FROM: Gary S. Hamada, Administrator
Disability Compensation Division

SUBJECT: Standardized Forms for Workers' Compensation Health Care Providers

Act 191 passed by the 2006 Legislature and approved by Governor Linda Lingle on June 14, 2006 requires the Director of the Department of Labor and Industrial Relations (DLIR), with input from interested stakeholders in the workers' compensation system, to establish standardized forms for medical service providers to use when reporting on or billing form injuries.

The DLIR convened a workshop on July 13, 2006 to allow interested stakeholders, including insurers, health care providers, employers and injured workers to present suggestions or recommendations on a standardized form. Twenty-three individuals attended the workshop. Comments and recommendations were submitted by the following parties:

1. Hawaii State Chiropractic Association, James A. Pleiss, D.C.
   (Enclosure A)
2. Ronald Gackle, M.D., Kaiser Hospitals
   (Enclosure B)
3. Hawaii Insurers Council, Janice Fukuda, First Insurance Company
   (Enclosure C)
4. Corvel, Kristy Kobayashi
   (Enclosure D)
5. IMS, Kris Kadzielawa
   (Enclosure E)
6. HEMIC, Michael Redman
   (Enclosure F)

Parties may request a copy of the comments and recommendations by contacting Mr. Clyde Imada at 587-8782 or via email at Clyde.T.Imada@Hawaii.gov. A follow-up workshop is scheduled for Thursday, August 31, 2006, at 1:00 p.m. at 830 Punchbowl Street,

Rooms 310, 313, and 314, Honolulu, Hawaii 96813. The treatment plan form proposals and billing forms will be discussed. The DLIR will be accepting comments and recommendations regarding the proposed forms.

The DLIR will review the comments and recommendations and will provide interested parties with proposed forms. A final workshop will be scheduled in September to solicit comments and recommendations on the proposed forms. The DLIR is optimistic that the final forms will provide all parties with essential information which will enable them to make proper decisions relating to medical billings and treatments. Comments have been made relating to when forms should be required. The DLIR may require amendments to our current rules in order to accommodate this issue.

If you have any questions, you may contact Mr. Clyde Imada at 587-8782.

Enclosures (6)

Hawaii State Chiropractic Association
P.O. Box 22668 Honolulu, HI 96823-2668
ph: (808) 926-8883 fx: (808) 926-8884
www.hawaiichiro.com

July 20, 2006

Gary Hamada
Administrator
Princess Keelikolani Bldg.
830 Punchbowl Street
Honolulu, HI 96813

RE: DLIR Workshop Comments and Recommendations

Dear Mr. Hamada:

Thank you for allowing the HSCA to work with the stakeholders in preparing standardized forms in workers' compensation.

I have been communicating with Janice Fukuda regarding a standardized treatment plan/progress form. I have attached a copy of the HSCA's latest version that we are recommending.

In working with Janice, we are in agreement with the majority of both our form's content with the exception of the following:

- The HSCA can not support the use of language in their "Proposed Treatment" section that states: "Within ODG guidelines…Yes…No... Other Guideline:…". As you know, guidelines are not mandated at this time. The language that would include the use of any specific guidelines is not appropriate in this form. Physicians are trained to consider many factors when making treatment recommendations including but not limited to: their training both in school and post-graduate training, their review of the current literature, all appropriate guidelines, standards of care, best practices, and their clinical experience.
    - I have spoken to Ron Gackle, MD, director of Occupational Medicine at Kaiser who is also not in favor of recognizing any specific guideline. In the spirit of compromise, if some sort of statement is necessary regarding treatment recommendations, both he and I would support language that stated the treatment was based on: "Evidence Based Best Practices".
- The only other area of relatively minor disagreement is in the "Measurable Objectives" section. We feel that there could be other measurable objectives besides just the ROM objectives. ROM by itself is not a good indicator for the need for treatment. For example: a person with normal ROM could still have functional limitations that require treatment; and a person with pre-existing degenerative disease would have reduced ROM even before an injury occurs and this would not be an accurate determination for treatment. We are more than willing to work together to make this section work. If ROM is determined to be the only measurable objective, then we can work with that.

Overall, the only real area of major disagreement is with the language of guidelines. Other than that, we have been able to work to come up with a form that will work for both the providers and insurers.

Regarding criteria for when a progress report would be necessary to be submitted in between submission of a treatment plan we recommend the following:

- A change in the patient's status
  - New injury
  - Worsening of patient's condition
  - New medical condition affecting recovery
- Request for diagnostic studies, consultation or additional treatment requests
- Referral for physical therapy, massage, etc that was not contained in previous treatment plans
- Request from carrier if there are questions regarding current status

As I stated in my power point, once the form is available, the DLIR, and representatives from the providers and insurers going out to the provider community on all islands to educate them on the use of this form would result in the highest compliance in its utilization.

I am emailing this to you with the original being faxed to you on 7/21/06. Please do not hesitate to call me if you need clarification regarding the above or have any other questions. We appreciate the opportunity to work with you.

Sincerely,

James A. Pleiss, DC, DABCO
President, Hawaii State Chiropractic Association

Cc: Ron Gackle, MD
Janice Fukuda
Board of Directors

Provider Letterhead with Address and Telephone number

Workers' Compensation Treatment Plan

Start: ____________ **End:** ____________

Patient: ________________ **DOI:** ____________ **Claim #:** ____________

Employer: ________________ **Phone:** ____________ **Contact:** ____________

Insurer: ________________ **Phone:** ____________ **Adjuster:** ____________

Frequency: ____________ **Number of Visits:** ____________ **Estimated Cost:** ____________

Diagnosis

1.	code	Description:	
2.	code	Description:	
3.	code	Description:	
4.	code	Description:	

Related pre-existing: ☐ Yes ☐ No Prior treatment under workers' compensation? ☐ Yes ☐ No

Prior Diagnosis & Status:

Current Complaints/Status:

Prognosis

☐ Full recovery probable ☐ Full recovery not probable ☐ Undetermined

Estimated **MMI** date: ____________ PPD expected: ☐ Yes ☐ No ☐ Undetermined

Disfigurement size: ____________ Location/Description: ____________

Proposed Treatment

Physician: medications, procedures, etc.

☐MD ☐DC ☐Other___ Visit frequency: _____ x/week for _____ weeks

Therapist: name address & phone-

☐PT ☐LMT ☐Other___ Visit frequency: _____ x/week for _____ weeks special instructions

Diagnostics: ☐ X-ray ☐ CT ☐ MRI ☐ EMG ☐ Other: ____________

of the ____________ to R / O ____________

Referral Requests: ☐Case Management ☐Conference ☐Impairment Rating ☐Voc.Rehab. ☐Other (↓)

☐Consult with: name, specialty, purpose of consult

Current Findings & Measurable Objectives

Prior Objectives Met: ☐ Yes ☐ No Comments: ____________

Cervical Range of Motion			
Flexion	_____ /50 to	_____ /50	
Extension	_____ /60 to	_____ /60	
R Rotation	_____ /80 to	_____ /80	
L Rotation	_____ /80 to	_____ /80	
R Lat Flex	_____ /45 to	_____ /45	
L Lat Flex	/45 to	/45	

Lumbar Range of Motion		
Flexion	_____ /60 to	_____ /60
Extension	_____ /25 to	_____ /25
R Lat Flex	_____ /25 to	_____ /25
L Lat Flex	/25 to	/25

Other ROM: joint			
motion	_____	to	_____
motion	_____	to	_____
motion	_____	to	_____
motion		to	

Visual Analog Pain Scale: Current: _____ /10 Goal: _____ /10

Ortho/Neuro Test: ____________ Current: ____________ Goal: ____________

Muscle Spasm: ____________ Current: ____________ Goal: ____________

Muscle Weakness: ____________ Current: ____________ Goal: ____________

Other Measures: ____________ Current: ____________ Goal: ____________

Physician Signature: ____________ Date: ____________

Provider Letterhead with Address and Telephone number

Patient: ______________________________ **DOI:** _________________________

Employer: ____________________________ **Insurance Carrier:** _________________________

Occupation: ___________________________

APPROVED WORK ACTIVITIES

☐ Full Duty **Effective:** ____/____/____

☐ Modified Duty **From**: ____/_____/____ **To**: _____/ _____/_____ ____hours/day

☐ Disabled **Effective:** ____/____/____ Anticipated RTW: ____/____/____

☐ Work Station Evaluation needed

PHYSICAL LIMITATIONS:

☐ Standing _____ Hrs. at one time ______ Total Hrs. Per Day

☐ Sitting _______ Hrs. at one time ______ Total Hrs. Per Day

☐ Walking _____ Hrs. at one time ______ Total Hrs. Per Day

Lifting MAXIMUM lbs.	80+	70	60	50	40	30	20	10	5
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐	☐

Carrying MAXIMUM lbs.	80+	70	60	50	40	30	20	10	5
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐	☐

Restricted ☐ Bend at waist ☐ Reach ☐ Squat ☐ Kneel ☐ Other __________

Activities: ☐ Push/Pull ____ Lbs. ☐ Climb steps ☐ Climb ladder

Additional Comments or
Other Physical Restrictions: ____

Ronald Gackle, M.D., Kaiser Hospitals

With regard to Gary Hamada's request for input as to what should trigger an interim WC-2 to be filed by the treating physician:

When the case changes direction.
When an MRI or other diagnostic imaging >$500 is needed.
When a consultation is requested.
When the diagnosis changes or there in an add-on.
When requesting a NCM or IME.
When surgery is recommended.
When the patient changes (or wants to change) providers.
When patient is declared stable and MMI.

Also recommend removal of referrence to an unproven commercial product such as "ODG" in the PROPOSED TREATMENT box and suggest replace with:

"Within evidence based best practices [ ] Acceptable standard treatment guideline [ ] Other [ ]
__________________ "

____
____

"Other" may include atypical or extenuating circumstances requiring unique or individualized care plan explained in body of visit report.

My thanks and appreciation for input to Paul J. Smith, M.D. and Patricia Walcyk, D.O.

July 21, 2006

Gary Hamada – Administrator
Dept. of Labor, DCD
830 Punchbowl Street
Honolulu, HI 96813

RE: DLIR Proposed Standardization of Workers Compensation Forms

Dear Mr. Hamada,

This is in response to your July 13, 2006 workshop regarding standardization of Workers Compensation forms. On behalf of the Hawaii Insurers Council, I would like to submit the attached form for your consideration.

Our goal is to reduce paperwork and improve the efficiency of the treatment approval process. The proposed form will replace three forms currently being used by providers of service:

1. Disability slip
2. WC-2
3. Treatment plan

Our recommendation is to replace the existing WC-2 form. HRS386-96 requires providers of service to submit reports in a timely manner that addresses all of the criteria listed on our proposed form:

- Current Diagnosis
- Current Prognosis
- Status of recovery (improving, worsening – objectives met on our form)
- Date of “medical stabilization”
- Dates of disability
- Any work restrictions
- Return to work date (full time, regular, light, part-time, or restricted)

The following information required by HRS386-96 should be included in the SOAP or clinical notes that are submitted with the HCFA1500 billing form:

- Information on the nature of examination and treatment
- Dates of treatments
- Results obtained within the treatment period
- Information on all tests performed within the treatment period and the results

The WC-2 report is required within seven days after the date of first attendance or service rendered. Interim reports are required at 'appropriate intervals' to verify the claimant's continued treatment, periods of temporary disability, etc. A change in the injured worker's recovery status that would require a change in the prognosis, the treatment plan, disability status etc. would trigger the need for an interim report.

Section 12-15-34 of the Workers Compensation Medical Fee Schedule requires physicians to include the following in their treatment plan request:

- Projected commencement and termination dates of treatment
- A clear statement as to the impression or diagnosis
- A specific time schedule of measurable objectives to include baseline measurements at the star of the treatment plan and projected goals by the end of the treatment plan
- Number and frequency of treatments
- Modalities and procedures to be used and
- An estimated total cost of services

Although 12-15-34 limits the number of treatments within a specified period for a treatment plan, it does not preclude a physician from requesting treatment in excess of this requirement. Referencing evidence-based guidelines to substantiate the requested treatment as 'reasonable and necessary' would expedite the approval process.

The HCFA1500 and well-documented SOAP notes along with our proposed WC-2 form satisfies existing requirements of HRS 386-96 and 12-15-34. We feel that adoption of these forms will reduce the 'paperwork' and expedite the approval process for treatment requested by the attending physician. It is our intent that these forms will encourage providers of service to focus on the goal of returning the injured workers to employment and pre-injury status.

Sincerely,

Janice Fukuda
AVP WC Claims/SIU/Bill Review

Attachment – Proposed WC-2 form 2006

Provider Letterhead with Address and Telephone number

WC-2 PHYSICIAN'S REPORT

☐ **FIRST** ☐ **FIRST AND FINAL** ☐ **INTERIM** ☐ **FINAL**

Patient: ______ **DOI:** ______ **Claim #:** ______
Employer: ______ **Phone:** ______ **Contact:** ______
Insurer: ______ **Phone:** ______ **Adjuster:**

Diagnosis

1.	code	Description:		3.	code	Description:	
2.	code	Description:		4.	code	Description:	

Pre-existing: ☐ Denies Prior Treatment under workers' compensation? ☐ Yes ☐ No

1.	code	Description:		3.	code	Description:	
2.	code	Description:		4.	code	Description:	

Accident Description/Patient History: ______

Current Complaints/Status: ______

Prognosis

☐ Full recovery anticipated ☐ Full recovery not anticipated ☐ Undetermined

MMI date: ______ PPD expected: ☐ Yes ☐ No ☐ Undetermined

Disfigurement size: ______ Location/Description: ______

PROPOSED TREATMENT PLAN - Start Date: End Date: Est. Cost:

Type: ______ x per week for ______ weeks Other: ______

☐ Request **IME** ☐ Request **FCE** ☐ Request **Consult**: Name of Physician

Analgesic Rx: ______ Specialty: ______

Anti-inflammatory: ______ Reason: ______

Within ODG guidelines ☐ Yes ☐ No ☐ Other Guideline: ______

Diagnostics: ☐ X-ray ☐ CT ☐ MRI ☐ EMG ☐ Other: ______

of the ______ to rule out ______

Approved: ☐ Yes ☐ No Adjuster: ______ Date: ______

Measurable Objectives

Prior Objectives Met: ☐ Yes ☐ No - Explain: ______

Cervical Range of Motion		
Flexion	/50 to	/50
Extension	/60 to	/60
R Rotation	/80 to	/80
L Rotation	/80 to	/80
R Lat Flex	/45 to	/45
L Lat Flex	/45 to	/45

Lumbar Range of Motion		
Flexion	/60 to	/60
Extension	/25 to	/25
R Lat Flex	/25 to	/25
L Lat Flex	/25 to	/25

Other:	
Flexion	to
Extension	to
	to
	to

☐ Request ***case management*** ☐ Request ***PPI*** exam

☐ Request ***team conference*** ☐ Other: ______

Physician Signature: ______ Date: ______

Provider Letterhead with Address and Telephone number

Patient: ______________________________ **DOI:** __________________________

Employer: ______________________________ **Insurance Carrier:** __________________________

WORK STATUS / APPROVED ACTIVITIES

☐ Full Duty **As of:** ____/____/____

Job Description: Provided by employer or insurance carrier

Modified duty available? ☐ Yes ☐ No

☐ Modified Duty ______ Hrs per day **From**:____/_____/____ **To**: _____/ ____/_____

☐ Work Station Evaluation needed ☐ Request Baseline FCE

PHYSICAL CAPABILITIES:

☐ Standing _____ Hrs. at one time ______ Total Hrs. Per Day

☐ Sitting _______ Hrs. at one time ______ Total Hrs. Per Day

☐ Walking _____ Hrs. at one time ______ Total Hrs. Per Day

Lifting MAXIMUM lbs.	80+	70	60	50	40	30	20	10
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐

Carrying MAXIMUM lbs.	80+	70	60	50	40	30	20	10
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐

Allowed to: ☐ Bend ☐ Reach ☐ Squat ☐ Kneel ☐ Climb

☐ Push/Pull _____ Lbs.

Additional Comments / Other Restrictions: ______________________________

CORVEL

July 19, 2006

Clyde Imada, Workers Compensation Chief
Department of Labor and Industrial Relations
830 Punchbowl Street, Room 209
Honolulu, HI 96813

Re: Standardized Forms for Workers Compensation Health Care Providers

Dear Mr. Imada:

Thank you for the opportunity to provide suggestions and comments on standardizing forms for medical service providers to use when reporting on and billing for work related injuries. As you know, CorVel Corporation provides medical bill auditing, medical case management and a provider network (over 900 throughout the state) to its customers for both workers compensation and auto insurance. After the workshop and further thought we have the following suggestions and comments:

- Most providers are already billing on HCFA and UB forms, there are still some providers that do not. We recommend that ALL providers bill on HCFA and UB forms. Documentation supporting the billing/CPT codes should meet the American Medical Association CPT guidelines.

- We support doing away with the WC-2 forms for progress documentation as providers in order to get payment must submit documentation with their billing statements, such that WC-2 forms are redundant.

- We do like HIC's proposal with the addition on treatment plan page a box for vocational rehabilitation and on the Approved Activities page made the font smaller to incorporate Job Title, Job Description (heavy, medium, light, sedentary) and whether light duty or alternate work available with employer and under Modified Duty add "Next Review Date".

- Some providers submit "cookie cutter" type reports where providers appear to be providing same documentation from previous office visits with very little change. It would be beneficial for providers to document objective findings to assess progress or lack of.

CorVel Corporation
Www.corvel.com

Pacific Park Plaza
711 Kapiolani Boulevard, Suite 150
Honolulu, HI 96813-5249

808.593.1430 phone
808.593.1444 fax
888.383.3803

CORVEL

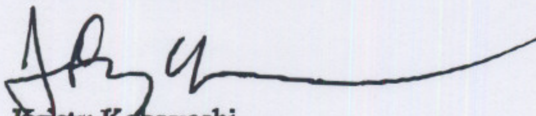
- Combining treatment plan and progress reports would greatly reduce the paperwork as treatment plans should include documentation justifying need for the treatment request which is usually documentation included in progress reports. However, in order to insure payers review treatment plans timely providers as currently required must state "TREATMENT PLAN REQUEST".

- In regards to hospital billing/statements. It is correct that billing by DRGS would be easier for the hospitals but reimbursement would be much less than the current fee schedule allows. Majority of the hospital bills that we see are using CPT codes when applicable.

We understand that use of forms cannot be mandatory at this time, we would suggest that forms either by administrative rules or legislatively be made mandatory to insure consistency and compliance.

Thank you again for your time and consideration. Should you have any questions, please feel free to contact me at 593-1430 ext. 310.

Very truly yours,



Kristy Kobayashi
Hawaii Branch Manager

CorVel Corporation
Www.corvel.com

Pacific Park Plaza
711 Kapiolani Boulevard, Suite 150
Honolulu, HI 96813-5249

808.593.1430 phone
808.593.1444 fax
888.383.3803

JUL-20-2006 12:31 CORVEL CORPORATION P.03

841 Bishop Street Suite 2250
Honolulu HI 96813
Tel: (808) 531-2273
www.audatex.com

2006 JUL 21 PM 1:58
DISABILITY COMPENSATION DIVISION

July 21, 2006 -Via Courier-

Clyde Imada
Workers' Compensation Chief
Department of Labor and Industrial Relations
State of Hawaii
830 Punchbowl Street, Room 209
Honolulu, Hawaii 96813

SUBJECT: Standardized Forms for Workers' Compensation Health Care Providers

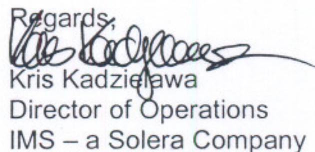
Dear Mr. Imada:

We suggest that the following forms (attached) be used as standard billing forms by Workers' Compensation Health Care Providers. These forms (the HCFA-1500 and the UB92) have been developed by the Center for Medicare Studies (Medicare/Medicaid) and are the standard throughout the US healthcare industry both in private and public health insurance sectors.

The HCFA-1500 is used for all outpatient services while the UB-92 is used for hospital services.

If you have any questions please call me at 531-2273 ext. 25.

Regards,

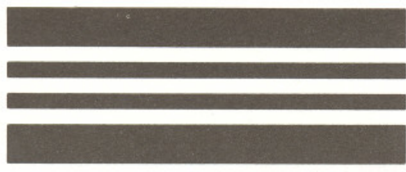


Kris Kadzielawa
Director of Operations
IMS – a Solera Company

Attachments: HCFA-1500
UB-92

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA



PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

N-SCF-MN

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPROVED OMB NO. 0938-0279

1

2

3 PATIENT CONTROL NO.

4. TYPE OF BILL

5 FED TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH

7 COV D.

8 N-C D.

9 C-ID.

10 L-R D.

11

12 PATIENT NAME

13 PATIENT ADDRESS

14 BIRTHDATE

15 SEX

16 MS

ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC

21 D HR

22 STAT

23 MEDICAL RECORD NO.

CONDITION CODES 24 25 26 27 28 29 30

31

32 OCCURRENCE CODE DATE

33 OCCURRENCE CODE DATE

34 OCCURRENCE CODE DATE

35 OCCURRENCE CODE DATE

36 OCCURRENCE SPAN CODE FROM THROUGH

37 A B C

38

39 VALUE CODES CODE AMOUNT

40 VALUE CODES CODE AMOUNT

41 VALUE CODES CODE AMOUNT

a b c d

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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3							
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23							

50 PAYER

51 PROVIDER NO.

52 REL INFO

53 ASG BEN

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56

A B C

57

DUE FROM PATIENT ▶

58 INSURED'S NAME

59 P.REL

60 CERT. - SSN - HIC. - ID NO.

61 GROUP NAME

62 INSURANCE GROUP NO.

A B C

63 TREATMENT AUTHORIZATION CODES

64 ESC

65 EMPLOYER NAME

66 EMPLOYER LOCATION

A B C

67 PRIN. DIAG. CD.

OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE

76 ADM. DIAG. CD.

77 E-CODE

78

79 P.C.

80 PRINCIPAL PROCEDURE CODE DATE

81 OTHER PROCEDURE CODE DATE A

OTHER PROCEDURE CODE DATE B

OTHER PROCEDURE CODE DATE C

OTHER PROCEDURE CODE DATE D

OTHER PROCEDURE CODE DATE E

82 ATTENDING PHYS. ID a b

83 OTHER PHYS. ID A a b

OTHER PHYS. ID B a b

84 REMARKS

85 PROVIDER REPRESENTATIVE

X

86 DATE

UB-92 CMS-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

OCR/ORIGINAL

Hi Clyde,

The following recommendations are what HEMIC proposes for ACT 191 Developing Workers' Comp Standardized Forms:

1) Provide CPT and ICD 9 Codes on the revised WC-2 and Treatment Plans forms.
2) Continue the use of the interim WC-2 report. This interim report is a very valuable tool when assessing the progress and status of the claimant's medical improvement. HEMIC would further recommend that the WC-2 interim report be revised so as to exclude redundant information already received as a result of the treatment plan submission.

Please let me know if you have questions or need additional clarification.

Thanks,
Michael Redman