



State of Michigan
Jennifer M. Granholm, Governor

Department of Energy, Labor & Economic Growth
Stanley "Skip" Pruss Director

Workers' Compensation Agency
Health Care Services Division
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MEMORANDUM

TO: Carriers and Service Companies

FROM: Health Care Services Division

DATE: June 10, 2009

SUBJECT: PROCEDURES FOR FILING THE ANNUAL MEDICAL PAYMENT REPORT (WC-406)

Attached is a copy of the Annual Medical Payment Report form which is to be used for reporting medical costs. The Annual Medical Payment Report should capture a carrier's total number of workers' compensation cases and the total health care dollars spent for those cases. The reporting period begins each year on January 1 and ends each year on December 31. The Annual Medical Payment Report is due into the Workers' Compensation Agency – Health Care Services Division by February 28 for the preceding calendar year. The report must be signed and may be submitted to the Health Care Services Division by mail, fax or email (with electronic signature).

All entities with a NAIC or a self-insured number must file an Annual Medical Payment Report per 418.101401(1).

The Annual Medical Payment Report will include all of the following information (see form):

1. **Carrier Information:** Carrier name (abbreviations are **not** acceptable), carrier NAIC number (if an insurance company) or self-insured number, carrier address (street), carrier telephone number (include area code), carrier city, state, zip code and carrier contact person. If a service company is completing the form please include the contact person and telephone number (with area code) of the person completing the form (for self-insured employers or group funds only).
2. **Annual Medical Payment Report Data:** Include payment data for all medical expenditures. **Do not** include indemnity payments, mileage reimbursements, vocational rehabilitation, rehabilitation case management expenses, independent medical evaluation(s) or any other costs other than **medical** payments. The following categories are used:
 - a. **Medical Only Cases:** Defined as those cases where no indemnity was paid. Do not count the number of bills for each case - only count cases! (Example: an

employee may have nine bills/claims for one date of injury but this should be counted as one case.) Refer to the Health Care Services Rules for the definition of case (418.10108).

b. **Medical Paid out on Wage Loss Cases:** Defined as those cases in which wage loss or indemnity was paid. For the purposes of this Annual Medical Payment Report, once wage loss benefits are paid, the case will always be reported as wage loss.

The person completing the form should sign their name (in ink), type their name in the second box provided, date the form and include their email address.

The methodology for reporting has been modified. The Agency no longer requires wage loss cases to be separated into hospitalized and non-hospitalized, and only requires that the services are reported as medical only or wage loss.

Service companies and insurance companies will report as follows:

- **SERVICE COMPANIES:** Individual self-insured employers submit one report for each self-insured client represented, noting the Self-Insured ID number assigned to that employer. This includes tail claims also if you are no longer the current active service company.

When a service company is hired by an insurance company to administer claims, the annual medical payment data for that insurance company must be forwarded to the insurance company. The insurance company will be responsible for compiling the data and submitting one consolidated report to the Agency.

- **GROUP SELF-INSURERS:** Submit one consolidated report for all employer members of the group self-insured client represented, noting the Self-Insured ID number assigned to the group.
- **SELF-ADMINISTERED EMPLOYERS OR SELF-ADMINISTERED GROUP FUNDS:** Submit their own reports.
- **INSURANCE COMPANIES:** Each insurance company must submit the Annual Medical Payment Report with their individual NAIC number for proper identification. They may not be combined with any other insurance company. If the insurance company is contracting with a servicing agent or a third party administrator, the insurance company is responsible for reporting this data to the Agency on their Annual Medical Payment Report.

*****Even if you are no longer doing business in the State of Michigan, you still must complete the annual medical report for all tail claims. Please note on form the date company discontinued doing business in Michigan.**

Questions regarding completion of the form may be directed to the Health Care Services Division at (517) 322-5433.

Attachment

ANNUAL MEDICAL PAYMENT REPORT

Michigan Department of Energy, Labor & Economic Growth
 Workers' Compensation Agency
 Health Care Services Division
 PO Box 30016, Lansing, MI 48909

ANNUAL REPORTING PERIOD: 1/01/_____ to 12/31/_____
(Due by February 28th the Year Following the Reporting Period)

I. CARRIER INFORMATION

Carrier Name (Insurance Co., Self-Insured, or Fund)	NAIC or Self-Insured No.
Address (number & street)	Telephone No. (include area code)
City, State, Zip Code	Carrier Contact Person and Email address
Service Co. Submitting Information for Self-Insured/Self-Administered	Service Co. Contact Person & Telephone No. (include area code)
Service Co./Self-Insured/Self-Administered Email Address	Service Co. Contact Person Email Address

II. ANNUAL MEDICAL PAYMENT REPORT

Include data for payment of all medical expenditures.

Do not include payments for the following:

- a. Indemnity payments
- b. Mileage reimbursement
- c. Vocational rehabilitation or medical case management expenses
- d. Independent medical examinations or legal expenses

CASE TYPE	NUMBER OF CASES	TOTAL DOLLARS SPENT FOR MEDICAL CARE
Medical Only Cases		\$
Medical Paid on Wage Loss Cases		\$

Are you continuing to do business in Michigan? (Check appropriate box) Yes No

If no, what is the termination date? _____

By signing this form, I certify that the information included in this annual medical payment report and accompanying attachments, if any, is true, correct and complete to the best of my knowledge.

Authorized Signature	Authorized Name and Email address	Date
Alternate Contact Person	Alternate Email Address	Alternate's Telephone Number

DELEG is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: Workers' Compensation Health Care Services Rules, part 14, R418.101401 Completion: Mandatory. Must be completed and submitted to the agency by 2/28 annually for the previous year. Penalty: Failure to provide data shall prevent certification of the Carrier's Professional Health Care Review Program pursuant to part 12, R418.101206
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