Medical Fee Guideline

Training module for health care & insurance professionals

Effective for services on or after August 1, 2003

Collage credit: Microsoft Design Gallery Live at http://www.microsoft.com

Published by: Texas Department of Insurance,
Division of Workers' Compensation

Revised 02/2006

MFG Training Module

The *Medical Fee Guideline (MFG)* Training Module is for educational purposes only. If a conflict exists between this curriculum and the statute or rules, then the statute and rules prevail. CPT codes and descriptions referenced in this document are a copyright of the American Medical Association.

Table of Contents

Goal and Objectives

Goal: At the conclusion of this training module, participants will understand the Division's *Medical Fee Guideline* and know where to go to obtain additional resources and training.

Objectives: At the conclusion of this training module, participants should be able to:

- Understand the basic concepts relevant to the *Medical Fee Guideline*;
- Submit bills that use coding and modifiers correctly;
- Use Web resources for coding, reimbursement, and policy decisions;
- Know how to stay current with Medicare policies changes;
- Understand the mathematical formulas for reimbursement; and
- Bill, code, and reimburse properly for DWC-specific services.

Four Basic Concepts

Basic Concept #1: Use of Medicare Policies

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants must apply the Medicare program reimbursement methodologies, models, and values or weights, along with its coding, billing, and reporting payment policies in effect on the date a service is provided, with any additions or exceptions in the MFG, Rule 134.202.

Basic Concept #2: Precedence of Act / Rules Over CMS Policy

Specific provisions contained in the Texas Workers' Compensation Act or Division of Workers' Compensation (DWC) rules shall take precedence over any conflicting provision adopted by or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. In other words, when there is a conflict between the Act/Rules and Medicare policies, the Act/Rules shall apply. Contact DWC Medical Review if you are unsure as to specific potential conflicts.

A payment policy used in the Medicare program must not be utilized for *Medical Fee Guideline* purposes if it will result in discrimination, which is prohibited by Insurance Code, Article 1451.104. See Advisory 2003-11 for more information.

For example, CMS allows chiropractors to be paid for manual spinal manipulations and correction of spinal subluxation. However, the Act and Rules allow chiropractors to be treating doctors and provide any health care that is within the scope of the Chiropractic Practice Act. So, notwithstanding CMS payment policies, chiropractors may be treating doctors and may be reimbursed for reasonable and medically necessary services provided within the scope of their practice act [Tex. Lab. Code §413.011(c)].

The scope of practice for doctors of chiropractic can be found in the Texas Occupations Code, Chapter 201 (www.capitol.state.tx.us/statutes/oc.toc.htm).

However, if a chiropractor provides a reasonable and medically necessary service that is within the scope of the Chiropractic Practice Act, then any existing Medicare policies regarding the service apply. For example, in Medicare chiropractors are limited to providing manual manipulation of the spine for purposes of correcting subluxation. Therefore, when manually manipulating the spine, chiropractors must abide by that Medicare policy.

Similarly, Medicare has an appeals process. However, DWC has a medical dispute resolution process, which takes precedence and should be applied. Please see Figure 1, "Medicare, DWC, and You" for more examples of situations in which DWC laws and rules take precedence over medicare policies.

Medicare, DWC, and You

Effective for services provided on or after August 1, 2003

Medicare	DWC	You Use
Appeal Process	133.305, 133.307 & 133.308 Medical Dispute Resolution	DWC rules supercede
Filing Deadline	134.801 Submitting Medical Bills for Payments	DWC rules supercede
Payment Deadline	133.304 Medical Payments & Denials	DWC rules supercede
Part B Billing Modifiers	134.202(e) *Medical Fee Guideline*	Both DWC-specific 134.202(e) & Medicare Part B modifiers
Anesthesia Conversion Factors	134.202(c)(1) *Medical Fee Guideline*	DWC rules supercede: for '06 use $37.8975 x 125%
Medicare CMS - 1500 Completion	DWC Form-67	Use DWC Form-67
Medicare Remittance Notice	DWC Form-62	DWC Form-62
Medicare Payment Exception Codes	133.1(a)(12), 133.304(C), DWC Form-62 DWC ANSI Claim Adjustment Reason Codes	133.1(a)(12), 133.304(C), DWC Form-62 DWC ANSI Claim Adjustment Reason Codes
Advanced Beneficiary Notice (ABN form and process)	408.021 Reasonable/ Necessary Charges related to compensable injury	DWC rules supercede; patient pays nothing
Part B Deductible & Coinsurance	408.021 Reasonable/ Necessary Related Charges	DWC rules; no deductibles/ coinsurance - patient pays nothing
Chiropractor - only manual manipulation of the spine	134.202(a)(3) *Medical Fee Guideline*	DWC rules; everything medically necessary within scope of practice act
No preauthorization requirements	134.600 Preauthorization, Concurrent Review and Voluntary Certification of Healthcare	DWC rules supercede
E/M Documentation Guidelines, 1995 & 1997	133.1 General Rule for Required Reports; Definitions	Both DWC and Medicare rules
Part B - covers injectable pharmacy items	Rule 134.202(c)(2) *Medical Fee Guideline*	DWC rules supercede
Part B - does not cover non-injectable pharmacy items	Rule 134 Subchapter F- Pharmaceutical Benefits	DWC rules supercede
LCD/LMRPs, Part B Newsletters, Limited Coverage policies, other misc. payment policies	134.202(a)(4) and (b) *Medical Fee Guideline*	DWC rule 134.202(a)(4) and (b); all Medicare policies apply, except medical necessity prevails
Medicare online fee database (RBRVS payment amounts)	Participating amount: Facility or Non-Facility x 125% depending on location of service	Participating amount: Facility or Non-Facility x 125% depending on location of service, with some exceptions
Medicare misc. (i.e., GPCI, HPSA, PSA, etc.) payment adjustments	134.202(b) *Medical Fee Guideline*	Use Medicare misc. payment adjustments in your calculation of MAR.

Figure 1

Basic Concept #3: Concurrent Updating

Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on or after the effective date of the revised component. In other words, when Medicare policy changes, the change is also simultaneously applicable to the Texas workers' compensation system.

For example, when Medicare adopts the new AMA CPT codes or a new conversion factor, DWC will require use of the new codes or conversion factor starting on the same dates that Medicare requires them.

Basic Concept # 4: Medically Necessary and Reasonable Health Care for Injured Workers

Any health care rendered in the Texas workers' compensation system is based on the injured worker's entitlement to reasonable and necessary medical benefits related to the compensable injury, as stated in the Act:

An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

(1) cures or relieves the effects naturally resulting from the compensable injury;

(2) promotes recovery; or

(3) enhances the ability of the employee to return to or retain employment [Tex. Lab. Code §408.021(a)].

Notwithstanding CMS payment policies and CMS medical review policies, in the Texas workers' compensation system, a given treatment or service should be covered if it is related to a compensable injury, medically necessary, and medically reasonable. For example, Medicare benefits exclude reimbursement for hearing aids; however, a hearing aid may be a medically necessary and reasonable item for an injured worker and thus reimbursable in the Texas workers' compensation system.

Medical necessity is established on a case-by-case basis through one of the following processes:

- Insurance carrier's retrospective review of documentation;
- Preauthorization / concurrent review / voluntary certification; or
- Medical dispute resolution, including the Independent Review Organization (IRO) process.

The Division will monitor IRO decisions to determine whether Division rulemaking action is appropriate.

Billing and Coding

Health care providers must bill their "usual and customary charges." They are required to submit medical bills in accordance with Rule 134.202(b), the Act, and Division rules. This includes applicable Medicare documentation requirements.

Effective August 1, 2003, providers are required to submit bills using the most appropriate current codes in effect on the date(s) of service for the services rendered. These codes are available in various forms through commercial publishers.

- Current Procedural Terminology (CPT) codes from the American Medical Association's most current *Physicians' Current Procedural Terminology* (CPT code book)

- Healthcare Common Procedure Coding System (HCPCS) codes, which are maintained by CMS

Use the appropriate modifier following the CPT or HCPCS code. When more than one modifier is applicable to a single code, list each modifier on the bill.

(Instructions for CMS-1500).
Please see the DWC Form-62 (Explanation of Benefits) and the DWC Form-67

Tools and Resources

Listed below some tools and resources you may find relevant to the *MFG*. Your particular choice of resources will vary with your business needs. The "General Information" section (page 37) gives direction on how to obtain many of these tools.

- Rule 134.202 with Adoption Preamble and Supplemental Order/Preamble
- Current year ICD-9-CM book
- Current year HCPCS II book
- Current year CPT book
- CPT Coding Assistant
- National RBRVS sources
- Computer with CD-ROM and Internet Access
- Current National Correct Coding Policy Manual
- CMS Program Memoranda and Transmittals
- CMS Local Coverage Determination Policies
- Part B Texas (Trailblazer) Communication/Education/Manuals
- Part B Texas (Trailblazer) Newsletters
- Part B Texas Medicare Physician Fee Schedule Database
- Texas DMERC (Palmetto GBA) Medicare Supplier Manual
- Texas DMERC (Palmetto GBA) Medical Policies
- CMS Downloadable Fee Schedules
- Texas Medicaid Fee Schedules

Reimbursement

Reimbursement for professional medical services is the lesser of

- The health care provider's usual and customary charge, or
- The health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s).

DWC "Maximum Allowable Reimbursement" (MAR)

The DWC MAR for a service is the result of four numeric factors:

1. **RVU = Relative Value Unit.** In most cases, this is a nationally established number for each procedure code. RVU includes work RVU, practice expense (PE), and malpractice expense (MP).

2. **GPCI = Geographic Practice Cost Index.** This is a nationally established number for the locality where the service is provided.

3. **CF = Conversion Factor.** This is a dollar amount established nationally that is used in calculating payments under the Medicare Physician Fee Schedule.

4. **DWC Multiplier.** This is a number established by Division rule to convert Medicare reimbursement to the DWC MAR. The DWC Multiplier is 125% (1.25).

Calculating the MAR

Medicare-valued codes have established RVUs. In some instances, Medicare codes with established RVUs are not reimbursed in the Medicare system.

For CPT codes valued by Medicare, multiply the Medicare allowed amount for a participating physician or supplier (for either a facility or non-facility setting) by the DWC multiplier of 125%, with some exceptions, which will be discussed later. Unlike Medicare, there are no deductible or co-payment requirements in Texas workers' compensation.

The **facility** RVU applies when the professional service is performed in a hospital (inpatient, outpatient, and emergency room), ambulatory surgical center, or skilled nursing facility setting. The **non-facility** RVU applies when the professional service is performed in a physician's office or any place of service other than those listed above.

For every service assigned value by Medicare there is a specific MAR in the workers' compensation system. The MAR will vary depending upon the geographic area where the service is provided.

Out-of-state providers should be reimbursed according to the GPCI for their place of service.

There are eight GPCIs (localities) in Texas:

- Brazoria County
- Dallas County
- Galveston County
- Harris County
- Jefferson County
- Tarrant County
- Travis County
- All Other Texas Counties

For Out of State services; all other GPCIs can be found on CMS website.

Calculating MAR for Evaluation and Management, Medicine, Surgery, Radiology, Pathology, and Physical Medicine

Multiply the Medicare allowable for a participating provider (either a facility or a non-facility setting) by 125%. (The MARs for Anesthesiology, DME, Pathology/Lab, and Dental are calculated differently; they will be discussed later.) You may derive the MAR using the Internet, by doing the math, or using a commercial product.

Example #1 For our first example, we will use the Internet.

What is the MAR for CPT code 99213 provided in a non-facility (office) setting in Brazoria County?

Step 1. Go to the TrailBlazer Health Enterprises, LLC website at www.TrailBlazerhealth.com.

Step 2. If you have already registered on this site, sign in. If you have not, you must register to use the site. There is no cost to use this website.

Step 3. Click on Medicare Fee Schedule in the menu on the left.

Step 4. Select the year of the fee schedule you want (2006), your state (Texas), and your locality (Brazoria County) in the appropriate windows.

Step 5. Enter the procedure code (CPT) (and modifier if applicable) about which you seek information.

You may also obtain Medicare reimbursement information from the CMS website at www.cms.gov.

Step 6. Refer to the column that applies to the service provided (non-facility in this example) and find the "participating amount." This amount is $52.50.

Step 7. Multiply this amount by 1.25.

The result is $65.625.

⇨ The MAR for CPT code 99213 provided in Brazoria County in 2006 is $65.63.

Example #2 For this example, we will use mathematical formulas. The mathematical formula for calculating the MAR is:

MAR = [(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x (CF x 1.25)

What is the MAR for CPT code 99214 provided in San Antonio in a non-facility (office) setting?

Another option is to use a commercial product. Commercial products are helpful because they provide Medicare reimbursement information in addition to other Medicare payment policies. For example, commercial products compile information from Local Carrier Determinations (LCD), newsletters, and Correct Coding Initiative (CCI) Edits.

Step 1. Consult the Medicare National Physician Fee Schedule Relative Value File (manual or computer) for RVUs.

For the CPT code 99214 (non-facility):

- The work RVU is 1.10.
- The practice expense RVU is 1.03.
- The malpractice RVU is 0.05.

Step 2. Consult the Medicare National Physician Fee Schedule Relative Value File (manual or computer) for GPCIs.

For San Antonio (all other Texas counties):

- Work GPCI is 1.000.
- Practice Expense GPCI is 0.865.
- Malpractice Expense GPCI is 1.138.

Step 3. Use the current Medicare conversion factor. The 2006 Medicare conversion factor is $37.8975.

Step 4. Use the DWC multiplier. The DWC multiplier is 1.25 (125%). Plug these values, into the mathematical formula:

MAR = [(1.10 x 1.000) + (1.03 x 0.865) + (0.05 x 1.138)] x (37.8975 x 1.25)

MAR = (1.100 + 0.89095 + 0.0569) x (37.8975 x 1.25)

MAR = 2.0479 x $47.37

MAR = $97.01

⇨ The MAR for CPT code 99214 provided in San Antonio (non-facility) in 2006 is $97.01.

Example #3. What is the MAR for CPT code 98943, extra-spinal manipulation, provided in Austin in 2006 in a non-facility (office) setting?

In this example, the code is valued but not reimbursed by Medicare. In cases like this, the reimbursement information cannot be found on the TrailBlazer website. Therefore, mathematical calculation is necessary.

Step 1. Consult the Medicare National Physician Fee Schedule Relative Value File (manual or computer) for RVUs.

For the CPT code 98943 (non-facility):

- The work RVU is 0.4.
- The practice expense RVU is 0.24.
- The malpractice RVU is 0.01.

Step 2. Consult the Medicare National Physician Fee Schedule Relative Value File (manual or computer) for GPCIs.

For Austin (Travis county):

- Work GPCI is 0.100.
- Practice Expense GPCI is 0.880.
- Malpractice Expense GPCI is 1.047.

Step 3. Use the current Medicare conversion factor. The 2006 Medicare conversion factor is $37.8975.

Step 4. Use the DWC multiplier. The DWC multiplier is 1.25 (125%).

Step 5. After plugging in these values, here is the calculation:

MAR = [(0.4 x 1.000) + (0.24 x 0.880) + (0.01 x 1.047)] x (37.8975 x 1.25)

MAR = (0.4 + 0.2112 + 0.0105) x (37.8975 x 1.25)

MAR = 0.6217 x $47.37

MAR = $29.45

⇨ The MAR for CPT code 98943 provided in Austin (non-facility) in 2006 is $29.45.

Calculating MAR for Anesthesiology

According to Rule 134.202(c)(1), " . . . for service categories of Evaluation and Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

Medicare computes MAR for anesthesiology differently than the Texas workers' compensation system. CMS sets a national Medicare anesthesiology conversion factor, which is adjusted slightly, depending on locality. However, DWC uses the **same conversion factor** for anesthesiology ($37.8975 x 1.25) as for other Professional CPT service groupings.

The Medicare anesthesiology conversion factor that is applicable to San Antonio under the Medicare system is $16.86. The Texas workers' compensation system, does not use this conversion factor.

To calculate the MAR for anesthesiology services rendered in 2006 in which there are four time units and three base units, use this formula:

MAR = (Time + Base) x Medicare CF x 1.25

MAR = (4 + 3) x 37.8975 x 1.25

MAR = 7 x $47.37

MAR = $331.59

Calculating MAR for DME – Healthcare Common Procedure Coding System (HCPCS) Level II Codes A, E, J, K, and L

HCPCS codes are used for durable medical equipment (DME), prosthetics, orthotics, and supplies, including injectables.

To calculate the MAR, use 125% of the fee schedule amounts found in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule (DMEPOS).

If there is no Medicare rate in the DMEPOS schedule, then use 125% of the fee schedule amounts found in the Texas Medicaid DME Fee Schedule for Durable Medical Equipment / Supplies Report J, for HCPCS. **Please note that DWC has not adopted Medicaid payment policies.**

For example, in 2006 crutches, HCPCS code E0110-NU, are reimbursed $71.77 according to the Medicare DMEPOS schedule. In the DWC system, reimbursement will be ($71.77 x 1.25) = $89.71.

Calculating MAR for Clinical Pathology and Laboratory Services

Some pathology service codes are found in the Medicare Physician Fee Schedule (MPFS). In such instances, calculate reimbursement in the same way as described in "Calculating MAR for Evaluation and Management, Medicine, Surgery, Radiology, Pathology, and Physical Medicine."

If a pathology service code is not found in the MPFS, look it up in the Medicare Clinical Laboratory Fee Schedule.

Pathology / laboratory codes have technical and professional components. When using the Medicare Clinical Laboratory Fee Schedule, reimbursement amounts are as follows.

- Technical component = 125% of Medicare Clinical Laboratory Fee Schedule amount
- Professional component = 45% of MAR calculated for the technical component
- Whole procedure = sum of Technical and Professional components

For example, surgical pathology techinical component is found in the 2006 Medicare Clinical Laboratory Fee Schedule. Reimbursement under Medicare is for the technical component in the rest of Texas category is $109.80. Follow these steps to calculate the correct reimbursement in the Texas workers' compensation system:

- Technical component = ($109.80 x 1.25) = $137.25
- Professional component = ($137.25 x .45) = $61.76
- Whole procedure = ($137.25 + $61.76) = $199.01

Calculating MAR for Dental Treatments and Services

See Rule 134.303, 2005 Dental Fee Guideline

Reimbursement of Valid HCPCS (CPT) Codes Without an Assigned Value

Insurance carriers (carriers) are responsible for correctly reimbursing medically necessary workers' compensation treatments and services. This includes when no reimbursement value for a Healthcare Common Procedure Coding System (HCPCS) code can be found in the Medicare Physician Fee Schedule Data Base or TrailBlazer fee calculator.

With the adoption of Rule 134.202, Medical Fee Guideline (MFG), the Texas workers' compensation system began using Medicare coding, billing, reporting, and reimbursement methodologies, models, and values or weights for reimbursement of professional medical services provided on or after August 1, 2003. Reimbursement values for most HCPCS codes used in Texas workers' compensation may be found by using the Medicare Physician Fee Schedule Data Base or the fee calculator at www.trailblazerhealth.com under "Tools" and "Medicare Fee Schedule.

To reimburse health care providers for HCPCS codes for which neither the Centers for Medicare & Medicaid Services nor the Division of Workers' Compensation (DWC) has established specific reimbursement vales, subsection 134.202(c)(6) of the MFG requires carriers to "assign a relative value, which may be based on nationally recognized published relative value studies, published (DWC) medical dispute decisions, and values assigned for services involving similar work and resource commitments." An amount assigned by the carrier that is consistent with the requirements of this rule is the maximum allowable reimbursement (MAR) for those services.

Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) Payments

In accordance with Medicare policies, doctors who render and bill for medical services provided in a Health Professional Shortage Area (HPSA) are entitled to receive a 10 percent incentive payment.

Effective January 1, 2006, the modifier to bill for a HPSA, regardless of whether the HPSA is in a rural or urban area is —AQ.

Only doctors, as defined by the Texas Labor Code section 401.011(17), are eligible to receive the HPSA incentive payment in the Texas workers' compensation system. Non-physician practitioners, such as certified registered nurse anesthetists or physical or occupational therapists, are not eligible for HPSA payments.

Doctors who render and bill for medical services provided in a Physician Scarcity Area (PSA) continue to be entitled to a five percent incentive payment in 2006. When billing for a PSA, the services must include the —AR modifier.

Use of these modifiers is required, and allows the Division to monitor patterns of usual, customary, and reasonable medical charges, payments, and treatment protocols for Division-specific services.

- Use Division-specific modifiers [§134.202(e)(9)];
- Use any other Medicare modifiers that apply; and
- Indicate each modifier on the bill if more than one modifier applies.

Case Management

The function of case management in the Texas workers' compensation system is to effectively coordinate care and to facilitate the injured worker's timely and productive return to work. Case management consists of either team conferences or telephone calls with an interdisciplinary team, which may include the employer. Although the treating doctor is primarily responsible for case management, a referral provider may initiate and bill for case management. However, another provider, such as a surgeon to whom the injured worker is referred, can initiate communication [134.202(e)(3)].

To calculate the MAR for case management, use the methodology described above for CPT codes not valued by Medicare.

An interdisciplinary team may not include employees of the coordinating provider. A health care provider in a Return to Work Rehabilitation Program (RTW) program, as defined in Rule 134.202(e)(5), may not initiate case management because reimbursement for the program includes coordination of care. However, a health care provider outside the RTW program may initiate case management with a health care provider in a RTW program. In this case, both the health care provider outside the RTW program and the health care provider inside the RTW program should be reimbursed for reasonable and medically necessary case management.

Team conferences and telephone conversations should be triggered by a documented change in the condition of the injured worker. Documentation of case management must include the name and specialty of each individual attending the team conference or engaged in the telephone conversation. The provider should bill for case management using the appropriate AMA CPT code for team conferences and telephone calls. See Rule 134.202(e)(3) for more information.

Functional Capacity Evaluations

Rule 134.202(C)(4)(A)-(C) details the required elements when conducting a functional capacity evaluation (FCE). An FCE must include the following elements:

1. A physical examination and neurological evaluation;
2. A physical capacity evaluation of the injured area; and
3. Functional abilities tests.

A total of three FCEs for each compensable injury may be billed and reimbursed. Any FCE ordered by the Division does not count toward this total.

FCEs should be billed using the "Physical performance test or measurement . . . " CPT code with modifier "FC." Documentation is required.

To calculate reimbursement for FCEs, use the methodology described for CPT codes valued by Medicare.

FCE reimbursement is limited to:

- Initial test: 4 hours,
- Interim test: 2 hours,
- Discharge test: 3 hours (unless it is the initial test), and
- Division-ordered FCE: 4 hours.

Return to Work Rehabilitation Programs

There are four Return to Work (RTW) Rehabilitation Programs in Texas workers' compensation:

- **Work Conditioning** — General Occupational Rehabilitation Program
- **Work Hardening** — Comprehensive Occupational Rehabilitation Program
- **Chronic Pain Management** — Interdisciplinary Pain Rehabilitation Program
- **Outpatient Medical Rehabilitation**

To qualify as a Division RTW Rehabilitation Program, a program should meet the "Specific Program Standards" as listed in the most recent *Medical Rehabilitation Standards* manual by the Commission on Accreditation of Rehabilitation Facilities (CARF). Section one on the standards of Organizational Leadership, Management, and Quality apply only to CARF-accredited programs.

CARF is currently the only accrediting entity recognized by the Division for preauthorization and reimbursement purposes.

Accreditation by the CARF is recommended, but not required, for participation in the Texas workers' compensation system. CARF-accredited programs are reimbursed 100 percent of the Maximum Allowable Reimbursement (MAR). Non-CARF accredited programs are reimbursed 80 percent of the MAR.

Work Conditioning / General Occupational Rehabilitation Program

For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

The following guidelines are for billing and reimbursing Work Conditioning:

- Bill the first <u>two</u> hours of work conditioning as <u>one</u> unit using the "work hardening/conditioning; initial 2 hours" CPT code with the modifier "WC." Indicate one unit in the "units" column on the bill (box 24g of the CMS-1500).
- Bill <u>each additional</u> hour using the "work hardening/conditioning; each additional hour" CPT code with the modifier "WC." Indicate the number of hours in the "units" column on the bill (box 24g of the CMS-1500).
- CARF-accredited programs will add "CA" as a second modifier.
- Reimbursement is $36.00 per hour for CARF-accredited programs or $28.80 for programs that are not CARF-accredited—80 percent of the $36.00 MAR.
- Reimbursement for less than one hour is prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to eight minutes and less than 23 minutes.
- Individual providers in the program may not bill individually.

For example, for one hour and thirty-five minutes, the entire time should be billed as one unit with supporting documentation to indicate the actual time spent in work conditioning. Reimbursement will be prorated as one hour and thirty minutes:

$36 + $18 = $54
for a CARF-accredited program, or

$54 x 80% = $43.20
for a non-CARF-accredited program.

Work Hardening / Comprehensive Occupational Rehabilitation Program

Follow these guidelines for billing and reimbursing Work Hardening:

For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

- Bill the first two hours of work conditioning as one unit using the "work hardening conditioning; initial 2 hours" CPT code with the modifier "WH." Indicate one unit in the "units" column on the bill (box 24g of the CMS-1500).
- Bill each additional hour using the "work hardening / conditioning; each additional hour" CPT code with the modifier "WH." Indicate the number of hours in the "units" column on the bill (box 24g of the CMS-1500).
- CARF-accredited programs will add "CA" as a second modifier.
- Reimbursement is $64.00 per hour for CARF-accredited programs or $51.20 for programs that are not CARF-accredited—80 percent of the $64.00 MAR.
- Reimbursement for less than one hour is prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to eight minutes and less than 23 minutes.

For example, for two hours and forty minutes, the initial two hours should be billed as one unit. The remaining forty minutes should be billed as one unit on a separate line. Supporting documentation must indicate the actual time spent in work hardening. Reimbursement will be prorated as two hours and forty-five minutes:

[($64 x 2) + ($64 x 0.75)] = $128 + $48 = $176
for a CARF-accredited program, or

$176 x 80% = $140.80
for a non-CARF-accredited program.

Outpatient Medical Rehabilitation Program (as defined by CARF)

Although many outpatient medical rehabilitation programs include physical therapy, stand-alone physical therapy services are not necessarily indicative of an outpatient medical rehabilitation program. (A program should meet the "Specific Program Standards" as listed in the most recent *Medical Rehabilitation Standards* manual by the Commission on Accreditation of Rehabilitation Facilities (CARF), as mentioned above).

Following are the guidelines for billing and reimbursing Outpatient Medical Rehabilitation Programs:

- Bill this program using the "Unlisted physical medicine/rehabilitation service or procedure" CPT code with the modifier "MR" for each hour.
- Indicate the number of hours in the "units" column on the bill (box 24g of the CMS-1500).
- CARF-accredited programs will add "CA" as a second modifier.
- Reimbursement for CARF-accredited programs is $90.00 per hour or $72.00 for programs that are not CARF-accredited—80 percent of the $90.00 MAR.
- Reimbursement for less than one hour is prorated in 15-minute increments. One 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to 8 minutes and less than 23 minutes.

For example, six hours and five minutes should be billed as seven units with supporting documentation to indicate the actual time spent in outpatient medical rehabilitation. Reimbursement will be prorated as six hours:

$90 x 6 = $540
for a CARF-accredited program, or

$540 x 80% = $432.00
for a non-CARF-accredited program.

Chronic Pain Management / Interdisciplinary Pain Rehabilitation Programs

Following are the guidelines for billing and reimbursing Chronic Pain Management / Interdisciplinary Pain Rehabilitation Programs:

- Bill this program using the "Unlisted physical medicine/ rehabilitation service or procedure" CPT code with the modifier "CP" for each hour.
- Indicate the number of hours in the "units" column on the bill (box 24g of the CMS-1500).
- Programs that are CARF-accredited will add "CA" as a second modifier.
- Reimbursement is $125.00 per hour for CARF-accredited programs or $100.00 per hour if not CARF-accredited.
- Reimbursement for less than one hour is prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to eight minutes and less than 23 minutes.

For example, three hours and twenty minutes should be billed as four units with supporting documentation to indicate the actual time spent in chronic pain management. Reimbursement will be prorated as three hours and fifteen minutes:

[($125 x 3) + ($125 x 0.25)] = $375 + $31.25 = $406.25
for a CARF-accredited program, or

$406.25 x 80% = $325
for a non-CARF-accredited program.

Maximum Medical Improvement and Impairment Rating Examinations

This section is organized into four main parts:

- General Information that Applies to All Doctors
- Information that Applies to Treating Doctors and Other Doctors Who Have Previously Treated the Injured Worker
- Information that Applies to Other Doctors Who Have Not Previously Treated the Injured Worker
- Billing and Reimbursement for Assignment of an Impairment Rating (applies to all doctors)

General Information that Applies to All Doctors

For dates of service on and after September 1, 2003, providers may bill and be reimbursed for an MMI / IR exam only if the examining doctor is an Impairment Rating doctor [Rule 180.24].

The Maximum Allowable Reimbursement (MAR) for a Maximum Medical Improvement (MMI) / Impairment Rating (IR) exam is the MMI evaluation reimbursement plus reimbursement for the body area(s) evaluated for assignment of an IR. Reimbursement for the MMI / IR includes reimbursement for the following components:

- Examination;
- Consultation with injured worker;

- Review of medical records and films;
- Reports, including the initial narrative report as well as any subsequent reports in response to the need for clarification, explanation, or reconsideration;
- Calculations, tables, figures, and worksheets; and
- Tests used to assign an IR, as outlined in the AMA's *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*) [as stated in the Act and Chapter 130 rules].

To bill for an MMI / IR exam, enter the following information in block #24 of the CMS-1500:

- MMI evaluation CPT code;
- Appropriate modifiers;
- Units (musculoskeletal body areas); and/or
- CPT code(s) for test(s) required for non-musculoskeletal areas rated.

Information that Applies to Treating Doctors and Other Doctors Who Have Previously Treated the Injured Worker

Use the following billing and reimbursement guidelines:

- Report the "Work related or medical disability examination by the treating physician . . ." CPT code;
- Use the modifer "V1," "V2," "V3," "V4," or "V5" to correspond with the last digit of the applicable established patient office visit code; and
- MMI Evaluation reimbursement is currently the same as the corresponding office visit fees.

If the treating (examining) doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not required and only the MMI evaluation portion of the examination is billed and reimbursed.

The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor. The following billing and reimbursement guidelines will apply:

- Report the "Work related or medical disability examination by the treating physician . . ." CPT code;
- Use the modifier "VR" to indicate a review of the report only; and
- Reimbursement is $50.00.

Information that Applies to Other Doctors Who Have Not Previously Treated the Injured Worker

If the examining doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not required and only the MMI evaluation portion of the examination is billed and reimbursed.

If the examining doctor (other than the treating doctor) determines that MMI has not been reached, the MMI evaluation portion of the exam is billed using the "Work related or medical disability examination by other than the treating physician . . ." CPT code with the appropriate modifier.

In this instance, use the following billing and reimbursement guidelines:

- The referral doctor bills using the "Work related or medical disability examination by other than the treating physician . . ." CPT code;
- If the patient is not at MMI, then the provider uses the "NM" modifier; and
- MMI Evaluation reimbursement is $350.00, regardless of whether the injured worker is at MMI or not.

When multiple IRs are required as a component of a designated doctor examination [see Rule 130.6], the following guidelines apply:

- The designated doctor bills for the number of body areas rated;
- Reimbursement is $50.00 for each additional IR calculation; and
- Add the modifier "MI" to the MMI evaluation CPT code.

If additional testing that is not outlined in the AMA *Guides* is required, use the appropriate CPT code(s) for that service in addition to the MMI/IR fees described in this section.

Billing and Reimbursement for Assignment of an Impairment Rating (applies to all doctors)

General

To bill for an IR evaluation, enter the following information in block 24 of the CMS-1500:

If the examining doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not required and only the MMI evaluation portion of the exam is billed and reimbursed.

- MMI evaluation CPT code;
- Appropriate modifiers; and
- Units (number of body areas rated).

Musculoskeletal Body Areas

The examining doctor may bill for a maximum of three musculoskeletal body areas, which are defined as follows:

- Spine and pelvis;
- Upper extremities and hands; and
- Lower extremities (including feet).

The MAR for musculoskeletal body areas is as follows:

- $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA *Guides*, 4th edition, is used.

Component modifiers:

- **WP = Whole Procedure (100% reimbursement)**
- **26 = Professional Component (80% reimbursement)**
- **TC = Technical Component (20% reimbursement)**

If a full physical evaluation with a range of motion test is performed, the MAR is as follows:

- $300 for the first musculoskeletal body area in which range of motion is measured, and
- $150 for each additional musculoskeletal body area.

If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the following guidelines apply:

- Examining doctor bills using the appropriate MMI CPT code with the modifier "WP," and
- Reimbursement is 100 percent of the total MAR.

If the examining doctor performs the MMI examination and assigns the IR, but does not perform the testing of the musculoskeletal body area(s), the following guidelines apply:

- Examining doctor bills using the appropriate MMI CPT code with the modifier "26," and
- Reimbursement is 80 percent of the total MAR.

If a health care provider other than the examining doctor performs the testing of the musculoskeletal body area(s), the following guidelines apply:

- HCP bills using the appropriate MMI CPT code with modifier "TC," and
- Reimbursement is 20 percent of the total MAR.

Non-musculoskeletal Body Areas

Non-musculoskeletal body areas are billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

For a complete list of body systems, body structures, and non-musculoskeletal body areas, refer to the appropriate AMA *Guides*.

Non-musculoskeletal body areas are defined as:

- Body systems;
- Body structures (including skin); and
- Mental and behavioral disorders.

If the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist and then incorporates the findings as part of the MMI/IR report, the following billing and reimbursement guidelines apply:

- The examining doctor (the referring doctor) bills using the appropriate MMI CPT code with modifier "SP."
- The examining doctor enters one unit in the "units" column (box 24g of the CMS-1500).
- Reimbursement is $50.00 for incorporating one or more specialist's report(s) information into the final assignment of IR.
- This $50 reimbursement is allowed only once per examination.
- The referral specialist bills and is reimbursed for the appropriate CPT code(s) for the tests required for the assignment of an IR. Documentation is required.

Return to Work (RTW) and Evaluation of Medical Care (EMC) Exams

When conducting a RTW or EMC examination requested by the Division or an insurance carrier that is for a purpose other than certifying MMI and/or assigning an IR (e.g., a medical necessity issue), the following billing and reimbursement guidelines apply:

- The examining doctor bills and is reimbursed using the "work related or medical disability examination by other than the treating physician . . ." CPT code.
- The examining doctor uses the modifier "RE."
- Reimbursement is $350.00 and includes Division-required reports.
- Required testing is billed using the appropriate CPT codes and is reimbursed in addition to the examination fee.

§134.202. Medical Fee Guideline

(a) Applicability of this rule is as follows:

(1) This section applies to professional medical services (health care other than prescription drugs or medicine, and the facility services of a hospital or other health care facility) provided in the Texas Workers' Compensation system.

(2) This section shall be applicable for professional medical services provided on or after September 1, 2002. For professional medical services provided prior to September 1, 2002, §134.201 and §134.302 of this title (relating to Medical Fee Guidelines) shall be applicable.

(3) Notwithstanding Centers for Medicare and Medicaid Services (CMS) payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(4) Specific provisions contained in the Texas Workers' Compensation Act (the Act), or Texas Workers' Compensation Commission (commission) rules, including this rule, shall take precedence over any conflicting provision adopted by or utilized by CMS in administering the Medicare program. Exceptions to Medicare payment policies for medical necessity may be provided by commission rule. Independent Review Organization (IRO) decisions regarding medical necessity are made on a case-by-case basis. The commission will monitor IRO decisions to determine whether commission rulemaking action would be appropriate.

(5) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with commission rules, decisions and orders for services rendered on or after the effective date of the revised component.

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.

(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:

(1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used.

(2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L:

(A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule;

(B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or

(C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.

(3) for pathology and laboratory services not addressed in subsection (c)(1) or in other commission rules:

(A) 125% of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

(B) 45% of the commission established MAR for the code derived in subparagraph (A) for the professional component of the service.

(4) for dental treatments and services 125% of the fee listed for the code in the Texas Medicaid Dental Fee Schedule in effect on the date the service is provided.

(5) for commission specific codes, services and programs (e.g. Functional Capacity Evaluation, Impairment Rating Evaluations, Return to Work Programs, etc.) as calculated in accordance with subsection (e) of this section.

(6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.

(d) In all cases, reimbursement shall be the least of the:

(1) MAR amount as established by this rule;

(2) health care provider's usual and customary charge; or,

(3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s).

(e) Payment policies relating to coding, billing, and reporting for commission-specific codes, services, and programs are as follows:

(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges. HCPs shall submit medical bills in accordance with subsection (b), the Act, and commission rules.

(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate American Medical Association (AMA) Physician's Current Procedural Terminology (CPT) code. Additionally, commission specific modifiers are identified in paragraph (9) of this subsection. When two modifiers are applicable to a single

CPT code, indicate each modifier on the bill.

(3) Case Management. Case Management is the responsibility of the treating doctor. Team conferences and phone calls shall include coordination with an interdisciplinary team (members shall not be employees of the coordinating HCP and the coordination must be outside of an interdisciplinary program). Documentation shall include the name and specialty of each individual attending the team conference or engaged in a phone call. Team conferences and phone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) the development or revision of a treatment plan;

(B) to alter or clarify previous instructions;

(C) to coordinate the care of employees with catastrophic or multiple injuries requiring multiple specialties; or,

(D) to coordinate with the employer, employee, and/or an assigned medical or vocational case manager to determine return to work options.

(4) Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the "Physical performance test or measurement..." CPT code with modifier "FC." FCEs shall be reimbursed in accordance with subsection (c)(1). Reimbursement shall be for up to a maximum of four hours for the initial test or for a commission ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(A) A physical examination and neurological evaluation, which include the following:

(i) appearance (observational and palpation);

(ii) flexibility of the extremity joint or spinal region (usually observational);

(iii) posture and deformities;

(iv) vascular integrity;

(v) neurological tests to detect sensory deficit;

(vi) myotomal strength to detect gross motor deficit; and

(vii) reflexes to detect neurological reflex symmetry.

(B) A physical capacity evaluation of the injured area, which includes the following:

(i) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and

(ii) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative data base. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(C) Functional abilities tests, which include the following:

(i) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);

(ii) hand function tests which measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;

(iii) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

(iv) static positional tolerance (observational determination of tolerance for sitting or standing).

(5) Return To Work Rehabilitation Programs. The following shall be applied for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/ Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a commission Return to Work Rehabilitation Program, a program should meet the "Specific Program Standards" for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual. Section 1 standards regarding Organizational Leadership, Management and Quality apply only to CARF accredited programs.

(A) Accreditation by the CARF is recommended, but not required.

(i) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100% of the MAR.

(ii) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80% of the MAR.

(B) Work Conditioning/General Occupational Rehabilitation Programs (for commission purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.)

(i) The first two hours of each session shall be billed and reimbursed as one unit, using the

"Work hardening/conditioning; initial 2 hours" CPT code with modifier "WC." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $36.00 per hour. Units of less than 1 hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(C) Work Hardening/Comprehensive Occupational Rehabilitation Programs (for commission purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.)

(i) The first two hours of each session shall be billed and reimbursed as one unit, using the "Work hardening/conditioning; initial 2 hours" CPT code with modifier "WH." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $64.00 per hour. Units of less than 1 hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(D) Outpatient Medical Rehabilitation Programs

(i) Program shall be billed and reimbursed using the "Unlisted physical medicine/ rehabilitation service or procedure" CPT code with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $90.00 per hour. Units of less than 1 hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(E) Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(i) Program shall be billed and reimbursed using the "Unlisted physical medicine/ rehabilitation service or procedure" CPT code with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $125.00 per hour. Units of less than 1 hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(6) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(A) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation

reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(i) the examination;

(ii) consultation with the injured employee;

(iii) review of the records and films;

(iv) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

(v) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (the AMA Guides), as stated in the commission Act and Rules, Chapter 130 relating to Impairment and Supplemental Income Benefits.

(B) A HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and commission Rules, Chapter 130 relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment.

(i) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with subparagraph (C). Modifier "NM" shall be added.

(ii) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with subparagraph (C).

(iii) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with subparagraphs (C) and (D).

(C) The following applies for billing and reimbursement of an MMI evaluation.

(i) An examining doctor who is the treating doctor shall bill using the "Work related or medical disability examination by the treating physician..." CPT code with the appropriate modifier.

(I) Reimbursement shall be the applicable established patient office visit level associated with the examination.

(II) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

(ii) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:

(I) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with subparagraph (C)(i); or,

(II) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with subparagraph (C)(iii).

(iii) An examining doctor, other than the treating doctor, shall bill using the "Work related or medical disability examination by other than the treating physician..." CPT code. Reimbursement shall be $350.

(D) The following applies for billing and reimbursement of an IR evaluation.

(i) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(ii) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

(iii) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(I) Musculoskeletal body areas are defined as follows:

(-a-) spine and pelvis;

(-b-) upper extremities and hands; and,

(-c-) lower extremities (including feet).

(II) The MAR for musculoskeletal body areas shall be as follows.

(-a-) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

(-b-) If full physical evaluation, with range of motion, is performed:

(-1-) $300 for the first musculoskeletal body area; and,

(-2-) $150 for each additional musculoskeletal body area.

(III) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100% of the total MAR.

(IV) If the examining doctor performs the MMI examination and assigns the IR, but does not perform the testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80% of the total MAR.

(V) If a HCP other than the examining doctor performs the testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." Reimbursement shall be 20% of the total MAR.

(iv) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(I) Non-musculoskeletal body areas are defined as follows:

(-a-) body systems;

(-b-) body structures (including skin); and,

(-c-) mental and behavioral disorders.

(II) For a complete list of body system and body structure non-musculoskeletal body areas refer to the appropriate AMA Guides.

(III) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:

(-a-) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50.00 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

(-b-) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.

(E) If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in subparagraphs (C) and (D).

(F) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and commission Rules, Chapter

130 relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by A Doctor Other Than The Treating Doctor. The treating doctor shall bill using the "Work related or medical disability examination by the treating physician..." CPT code with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.00.

(7) Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a commission or insurance carrier requested RTW/EMC examination that is not for the purpose of certifying MMI and/or assigning an IR (e.g., a medical necessity issue), the examining doctor shall bill and be reimbursed using the "Work related or medical disability examination by other than the treating physician..." CPT code with modifier "RE." The reimbursement shall be $350.00 and shall include commission-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

(8) Work Status Report. When billing for a Work Status Report refer to the commission Act and Rules, Chapter 129 relating to Income Benefits - Temporary Income Benefits.

(9) Commission Modifiers. HCPs billing professional medical services shall utilize the following modifiers, in addition to the modifiers prescribed by the Medicare policies required to be used in subsection (b) of this section, for correct coding, reporting, billing, and reimbursement of the procedure codes.

(A) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs - This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited.

(B) CP, Chronic Pain Management Program - This modifier shall be added to the "Unlisted physical medicine/rehabilitation service or procedure" CPT code to indicate Chronic Pain Management Program services were performed.

(C) FC, Functional Capacity - This modifier shall be added to the "Physical performance test or measurement..." CPT code when a functional capacity evaluation was performed.

(D) MR, Outpatient Medical Rehabilitation Program - This modifier shall be added to the "Unlisted physical medicine/rehabilitation service or procedure" CPT code to indicate Outpatient Medical Rehabilitation Program services were performed.

(E) MI, Multiple Impairment Ratings – This modifier shall be added to the "Work related or medical disability examination by other than the treating physician..." CPT code when the designated doctor is required to complete multiple impairment ratings calculations.

(F) NM, Not at Maximum Medical Improvement (MMI) - This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.

(G) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC) - This modifier

shall be added to the "Work related or medical disability examination by other than the treating physician..." CPT code when a RTW or EMC examination was performed.

(H) SP, Specialty Area - This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.

(I) TC, Technical Component - This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.

(J) VR, Review report - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code to indicate that the service was the treating doctor's review of report(s) only.

(K) V1, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to a "minimal" level.

(L) V2, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "self limited or minor" level.

(M) V3, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "low to moderate" level.

(N) V4, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration.

(O) V5, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.

(P) WC, Work Conditioning - This modifier shall be added to the appropriate "Work hardening/conditioning" CPT code to indicate work conditioning was performed.

(Q) WH, Work Hardening - This modifier shall be added to the appropriate "Work hardening/conditioning" CPT code to indicate work hardening was performed.

(R) WP, Whole Procedure - This modifier shall be added to the CPT code when both the professional and technical components of a procedure were performed by a single HCP.

(f) Where any terms or parts of this section or its application to any person or circumstance are determined by a court of competent jurisdiction to be invalid, the invalidity does not affect other provisions or applications of this section that can be given effect without the invalidated provision or application.

General Information

Medical Fee Guideline 28 T.A.C.

Rule §134.202

The Division of Texas Workers' Compensation adopted Rule §134.202, *Medical Fee Guideline* (*MFG*) on April 25, 2002. It was published in the *Texas Register* on May 10, 2002. The text of the rule can also be found on the Division's website at www.tdi.state.tx.us under "Rules."

APPLICABILITY

The *MFG* applies to professional medical services (healthcare other than prescription drugs or medicine and the facility services of a hospital or other healthcare facilities) provided on or after August 1, 2003.

DIVISION SPECIFIC SERVICES

Subsection (e) of the newly adopted *MFG* provides coding, billing, and reporting instructions for Division specific services. This includes:

- Case management services;
- Functional capacity evaluations;
- Return to work rehabilitation programs (program requirement information is available from the Division on Accreditation of Rehabilitation Facilities (CARF) at www.carf.org)
    - o Work conditioning/General Occupational Rehabilitation Programs
    - o Work hardening/Comprehensive Occupational Rehabilitation Programs
    - o Chronic pain management
    - o Outpatient medical rehabilitation;
- Maximum medical improvement/impairment rating examinations; and,
- Return to work/evaluation of medical care examinations.

ALL OTHER SERVICES

Coding & Billing

1) **For medical services**, the latest version of the American Medical Association's *Current Procedural Terminology* (AMA CPT) manual should be used. Information regarding the AMA CPT can be found at www.ama-assn.org/ama/pub/category/4555.html.

2) **For Durable Medical Equipment (DME)/supplies and dental services**, the latest version of the Healthcare Common Procedure Coding System (HCPCS) Level II manual should be used. Information regarding HCPCS can be found at www.ama-assn.org/ama/pub/category/4555.html and www.cms.hhs.gov./providers/pufdownload/default.asp.

Reimbursement

To calculate the DWC reimbursement for professional medical services, multiply the Medicare reimbursement amount for the specific service by 125%. This calculation is per subsection (c) of the adopted MFG rule. There are a number of ways to obtain the Medicare reimbursement amount.

1) **For reimbursement of medical services (excluding DME/Supplies, Pathology, and Dental services)**, the Texas Medicare carrier, Trailblazer Health Enterprises, has a website (www.trailblazerhealth.com) that provides detailed Medicare reimbursement information for free. Each user will need to register on this site. After registering, the process is very simple. The CPT code in question will need to be typed into the "Medicare Fee Schedule" tool and the current Medicare reimbursement amount and relevant information are provided.

2) **For reimbursement of medical services (including DME/Supplies, Pathology, and Dental services)**, Medicare's 2006 National Physician Fee Schedule Relative Value File, DMEPOS Fee Schedule, and Laboratory Fee Schedule may be obtained for free from the Centers for Medicare and Medicaid (CMS) website (www.cms.hhs.gov./providers/pufdownload/default.asp). The DMEPOS and Laboratory Fee schedules contain reimbursement amounts. The National Physician Fee Schedule Relative Value File contains the RBRVS relative value units (RVUs) for CPT codes. Detailed calculations will need to be made to obtain the reimbursement amount for these services.

3) **For DME/supplies not covered by Medicare,** Medicaid's DME fee schedule is to be used. This may be obtained from the Texas Medicaid Fee Schedule, Durable Medical Equipment/Medical Supplies Report J (www.tmhp.com).

4) There are also a variety of commercially available publications relating to Medicare coding, billing, reporting, and reimbursement policies.

Payment Policies

Medicare payment policies may be obtained from the following sources:

1) CMS website, www.cms.hhs.gov
2) Trailblazer website, www.trailblazerhealth.com
3) National Correct Coding Initiatives, www.cms.hhs.gov/NationalCarCodInitEdits

General Principles Regarding Reimbursement under Medical Fee Guideline (28 T.A.C. §134.202)

To achieve standardization, the Division adopted Rule §134.202 (*Medical Fee Guideline*) which, with some exceptions, uses the most current reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid (CMS), including applicable payment policies relating to coding, billing, and reporting. Payment policies that affect utilization of services are also applicable.

The Division's *Medical Fee Guideline* (*MFG*) adopts the Medicare policies regarding **efficacy** and **benefits coverage.** However, where Medicare payment policies conflict with the Division's act and rules, the Division's act and rules take precedence over any conflicting provisions.

The Medicare system may not reimburse for professional medical services because of:

- benefits coverage (types of services included or excluded in the Medicare system because of national/local coverage policies)
- efficacy of the service (services Medicare has not yet determined to be medically efficacious)

BENEFITS COVERAGE

When Medicare does not pay for a service based on benefits coverage of the Medicare program, this is not a basis for limitation of payment for a service provided to injured employees.

Section 408.021 of the Texas Labor Code (Entitlement to Medical Benefits) provides the coverage for workers' compensation injuries.

(a) A worker who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The worker is specifically entitled to health care that:

(1) cures or relieves the effects naturally resulting from the compensable injury;

(2) promotes recovery; or

(3) enhances the ability of the worker to return to or retain employment.

(b) Medical benefits are payable from the date of the compensable injury.

(c) Except in an emergency, all health care must be approved or recommended by the worker's treating doctor.

(d) An insurance carrier's liability for medical benefits may not be limited or terminated by agreement or settlement. *Acts 1993, 73rd Leg., ch. 269, § 1, eff. Sept. 1, 1993.*

Regarding **chiropractic services**, section 413.011(c) of the Texas Labor Code provides:

> This section may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Article 1451.104, Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. The Division shall also develop guidelines relating to fees charged or paid for providing expert testimony relating to an issue arising under this subtitle.

In addition, subsection (a)(3) of the *MFG* provides:

> Notwithstanding Centers for Medicare and Medicaid Services (CMS) payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

EFFICACY

When Medicare has determined that the medical efficacy of a type of service has not been proved, this is a reasonable basis for carriers to decline to pay for services. Exceptions to Medicare payment policies for medical necessity may be provided by Division rule. Independent Review Organization (IRO) decisions regarding medical necessity are made on a case-by-case basis.

- If the service to be provided is on the preauthorization list in Rule 134.600(h), medical necessity is determined in the preauthorization process.

- If the service to be provided is not on the preauthorization list in Rule 134.600(h), the provider will have to decide whether to provide the service and prove it medically necessary in dispute resolution if it is not reimbursed.

ACT AND DIVISION RULES TAKE PRECEDENCE

Subsection (a)(4) of the *MFG* provides:

> Specific provisions contained in the Texas Workers' Compensation Act (the Act), or Division of Workers' Compensation (Division) rules, including this rule, shall take precedence over any conflicting provision adopted by or utilized by CMS in administering the Medicare program. Exceptions to Medicare payment policies for medical necessity may be provided by Division rule. Independent Review Organization (IRO) decisions regarding medical necessity are made on a case-by-case basis. The Division will monitor IRO decisions to determine whether Division rulemaking action would be appropriate.

Evaluation of Medical Fee Guideline Training Module

(Online Format)

Today's Date: _____

Your input is very important! Please help us evaluate and improve this material by rating each of the areas listed below. We also invite your comments in the space provided. Thank you!

How long have you been participating in Texas workers' compensation?

❑ less than 1 yr. ❑ 1-5 yrs. ❑ 5-10 yrs. ❑ more than 10 yrs.

Please evaluate the usefulness of the topics covered in the training module.

	Extremely Useful	**Very Useful**	**Useful**	**Not Useful**
Goal and Objectives				
Four Basic Concepts				
Medicare, DWC, and You				
Billing and Coding				
Tools and Resources				
Reimbursement				
Division-Specific Services				

Please evaluate the level of instructional material for the following topics.

	Too Technical	**Just Right**	**Too Basic**
Goal and Objectives			
Four Basic Concepts			
Medicare, DWC, and You			
Billing and Coding			
Tools and Resources			
Reimbursement			
Division-Specific Services			

How would you rate the following aspects of the training module?

	Excellent	**Good**	**Fair**	**Poor**
Instructional content				
Graphics				
Navigability / ease of use				
Links				
Length of course				
Overall rating of course				

Which specific information was of greatest value to you?

_____

Which specific part(s) of the curriculum would you suggest we improve? How?

_____

Was there any portion(s) you did not understand or that was not clear? Please indicate the information that could be stated more clearly.

_____

How easy did you find this information on our website?

_____

Will this training module assist you in participating in the Texas workers' compensation system? If so, how? If not, why not?

_____

How long did it take you to read the material?

_____ Less than one hour

_____ One to two hours

_____ Two to three hours

_____ Three to four hours

_____ More than four hours

How did you hear about this training module?

_____ Email from DWC

_____ Word of mouth

_____ DWC website

_____ Other:_____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____