CHAPTER 134 BENEFITS – GUIDELINES FOR MEDICAL SERVICE, CHARGES AND PAYMENTS

SUBCHAPTER A - MEDICAL REIMBURSEMENT POLICIES

§134.1. Medical Reimbursement.

(a) "Maximum allowable reimbursement" (MAR), when used in this chapter, is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 of the Labor Code, and Division rules.

(b) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, except as provided in subsections (c) and (d) of this section.

(c) Examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 shall be reimbursed in accordance with §134.204 of this chapter (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

(d) Examinations conducted pursuant to Labor Code §408.0042 shall be reimbursed in accordance with §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(1) the Division's fee guidelines;

(2) a negotiated contract; or

(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

(f) Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

(g) The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts. Upon request of the Division, an insurance carrier shall provide copies of such documentation.

The provisions of this §134.1 adopted to be effective May 2, 2006, 31 TexReg 3561; amended to be effective January 17, 2008, 33 TexReg 428; amended to be effective March 1, 2008, 33 TexReg 626.

§134.2. Incentive Payments for Workers' Compensation Underserved Areas.

(a) When required by Division rule, an incentive payment shall be added to the maximum allowable reimbursement (MAR) for services performed in a designated workers' compensation underserved area.

(b) The following list of ZIP Codes comprise the Division designated workers' compensation underserved areas: 75134, 75135, 75161, 75181, 75212, 75410, 75558, 75603, 75630, 75650, 75653, 75654, 75658, 75660, 75663, 75666, 75667, 75672, 75687, 75692, 75704, 75750, 75752, 75763, 75789, 75849, 75915, 75933, 75949, 75964, 75969, 75973, 75980, 76023, 76055, 76060, 76066, 76088, 76119, 76226, 76239, 76247, 76271, 76380, 76443, 76534, 76621, 76640, 76657, 76682, 76711, 76932, 76935, 77033, 77050, 77053, 77078, 77336, 77354, 77363, 77389, 77396, 77466, 77496, 77517, 77561, 77632, 77808, 77905, 77968, 78025, 78123, 78132, 78140, 78141, 78210, 78220, 78239, 78242, 78333, 78335, 78343, 78368, 78370, 78383, 78407, 78535, 78574, 78583, 78590, 78605, 78640, 78669, 78802, 78830, 78836, 78877, 78884, 78935, 78960, 79010, 79107, 79108, 79114, 79118, 79311, 79367, 79408, 79411, 79511, 79521, 79536, 79561, 79563, 79778, 79782, 79836, 79838, 79849, 79901, 79922, 79934.

The provisions of this §134.2 adopted to be effective January 17, 2008, 33 TexReg 428; amended to be effective March 1, 2008, 33 TexReg 626.

SUBCHAPTER B. MISCELLANEOUS REIMBURSEMENT

§134.100. Reimbursement of Treating Doctor for Attendance at Required Medical Examination.

(a) When an injured employee's treating doctor is present at a required medical examination in accordance with §126.6 of this title (relating to Required Medical Examination), the insurance carrier shall reimburse the treating doctor for time as follows:

(1) at a rate of $100 an hour limited to four hours, unless the insurance carrier pre-approves extended time; and

(2) in quarter hour increments with any amount over 10 minutes considered an additional quarter hour.

(b) Reimbursement is limited to the time required to travel from the treating doctor's usual place of business to the place of the examination. In addition, it includes the duration of the examination and the time required to return from the examination location to the treating doctor's usual place of business. The travel shall be by the most direct route. This time does not include time spent for meals or other elective activities engaged in by the doctor.

(c) The treating doctor shall submit a request for reimbursement in accordance with §133.10 of this title (relating to Required Billing Forms/Formats).

(d) The injured employee's treating doctor shall be the only doctor permitted to attend and charge for the attendance at the examination.

(e) This section shall apply to all dates of travel on or after May 2, 2006.

The provisions of this §134.100 adopted to be effective May 2, 2006, 31 TexReg 3561.

§134.110. Reimbursement of Injured Employee for Travel Expenses Incurred.

(a) An injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when:

(1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives; and

(2) the distance traveled to secure medical treatment is greater than 30 miles, one-way.

(b) The injured employee shall submit the request for reimbursement to the insurance carrier within one year of the date the injured employee incurred the expenses.

(c) The injured employee's request for reimbursement shall be in the form and manner required by the Division and shall include documentation or evidence (such as itemized receipts) of the amount of the expense the injured employee incurred.

(d) The insurance carrier shall reimburse the injured employee based on the travel rate for state employees on the date travel occurred, using mileage for the shortest reasonable route.

(1) Travel mileage is measured from the actual point of departure to the health care provider's location when the point of departure is:

(A) the employee's home; or

(B) the employee's place of employment.

(2) If the point of departure is not the employee's home or place of employment, then travel mileage shall be measured from the health care provider's location to the nearest of the following locations:

(A) the employee's home;

(B) the place of employment; or

(C) the actual point of departure.

(3) Total reimbursable mileage is based on round trip mileage.

(4) When an injured employee's travel expenses reasonably include food and lodging, the insurance carrier shall reimburse for the actual expenses not to exceed the current rate for state employees on the date the expense is incurred.

(e) The insurance carrier shall pay or deny the injured employee's request for reimbursement submitted in accordance with subsection (c) of this section within 45 days of receipt.

(f) If the insurance carrier does not reimburse the full amount requested, partial payment or denial of payment shall include a plain language explanation of the reason(s) for the reduction or denial. The insurance carrier shall inform the injured employee of the injured employee's right to request a benefit review conference in accordance with §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference).

(g) This section shall apply to all dates of travel on or after May 2, 2006.

The provisions of this §134.110 adopted to be effective May 2, 2006, 31 TexReg 3561.

§134.120. Reimbursement for Medical Documentation.

(a) An insurance carrier is not required to reimburse initial medical documentation provided to the insurance carrier in accordance with §133.210 of this title (relating to Medical Documentation).

(b) An insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance carrier in accordance with §133.210 of this title.

(c) Upon request, the health care provider shall provide the injured employee, or the injured employee's representative, an initial copy of the medical documentation without charge. The requestor shall reimburse the health care provider for subsequent requests of the same medical documentation.

(d) If the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information.

(e) The health care provider shall provide copies of any requested or required documentation to the Division at no charge.

(f) The reimbursements for medical documentation are:

(1) copies of medical documentation--$.50 per page;

(2) copies of hospital records--an initial fee of $5.00 plus $.50 per page for the first 20 pages, then $.30 per page for records over 20 pages;

(3) microfilm--$.50 per page;

(4) copies of X-ray films--$8.00 per film;

(5) narrative reports:

(A) one to two pages--$100;

(B) each page after two pages--$40 per page.

(g) Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or equivalent electronic document format. Clinical or progress notes do not constitute a narrative report.

The provisions of this §134.120 adopted to be effective May 2, 2006, 31 TexReg 3561.

§134.130. Interest for Late Payment on Medical Bills and Refunds.

(a) Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.340 of this title (relating to Medical Payments and Denials).

(b) Health care providers shall pay interest to insurance carriers on requests for refunds paid later than the 60th day after the date the health care provider received the request for refund, in accordance with §133.260 of this title (relating to Refunds).

(c) The rate of interest to be paid shall be the rate calculated in accordance with Labor Code §401.023 and in effect on the date the payment was made.

(d) Interest shall be calculated as follows:

(1) multiply the rate of interest by the amount on which interest is due (to determine the annual amount of interest);

(2) divide the annual amount of interest by 365 (to determine the daily interest amount); then

(3) multiply the daily interest amount by the number of days of interest to which the recipient is entitled under subsection (a) or (b) of this section.

(e) The percentage of interest for each quarter may be obtained by accessing the Texas Department of Insurance’s website, www.tdi.state.tx.us.

(f) This section shall apply to all dates of service on or after May 2, 2006.

The provisions of this §134.130 adopted to be effective May 2, 2006, 31 TexReg 3561.

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SUBCHAPTER C - MEDICAL FEE GUIDELINES

§134.201. Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers'Compensation Act.

(a) The commission adopts by reference herein, the Texas Workers' Compensation Commission Medical Fee Guideline 1996. The Guideline shall be effective for all medical treatments, services, durable medical equipment and pharmaceuticals provided on or after April 1, 1996. Medical treatments, services, and durable medical equipment provided prior to April 1, 1996, shall be subject to the 1991 Texas Workers' Compensation Commission Medical Fee Guideline (December 1991 Version). Pharmaceuticals provided prior to April 1, 1996, shall be subject to §134.501 of this title (relating to the Pharmaceutical Fee Guideline). Copies of both guidelines may be obtained from the Publication Department of the Texas Workers' Compensation Commission, 4000 South IH-35, Southfield Building, Austin, Texas 78704.

(b) An insurance carrier or health care provider which willfully or intentionally violates the provisions of this rule commits an administrative violation under Texas Labor Code, §415.002 or §415.003, and may be assessed a penalty. In addition, an insurance carrier or health care provider which repeatedly violates these statutory provisions may be assessed a penalty not to exceed $10,000 under the Texas Labor Code, §415.021, and may be subject to the sanctions specified in the Texas Labor Code, §415.023, including, but not limited to, restriction or revocation of the right to receive reimbursement under the Texas Workers' Compensation Act.

The provisions of this §134.201 adopted to be effective April 1, 1996, 21 TexReg 2361.

§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 database. 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) on-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.

The provisions of this §134.202 adopted to be effective January 5, 2003, 27 TexReg 4048 and 12304. Per court order issued June 11, 2003, §134.202 is effective for professional medical services provided on or after August 1, 2003.

§134.203. Medical Fee Guideline for Professional Services.

(a) Applicability of this rule is as follows:

(1) This section applies to professional medical services provided in the Texas workers' compensation system, other than:

(A) workers' compensation specific codes, services, and programs described in §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services);

(B) prescription drugs or medicine;

(C) dental services;

(D) the facility services of a hospital or other health care facility; and

(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(2) This section applies to professional medical services provided on or after March 1, 2008.

(3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

(4) For professional services provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.

(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(6) Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(7) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(8) Whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later.

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

(2) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (c) – (f) and (h) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

(e) The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

(g) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

(i) Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II HCPCS codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(j) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Division-specific modifiers are identified and shall be applied in accordance with §134.204(n) of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services). When two or more modifiers are applicable to a single CPT code, indicate each modifier on the bill.

The provisions of this §134.203 adopted to be effective January 17, 2008, 33 TexReg 428; amended to be effective March 1, 2008, 33 TexReg 626.

§134.204. Medical Fee Guideline for Workers' Compensation Specific Services.

(a) Applicability of this rule is as follows:

(1) This section applies to workers' compensation specific codes, services and programs provided in the Texas workers' compensation system, other than:

(A) professional medical services described in §134.203 of this title (relating to Medical Fee Guideline for Professional Services);

(B) prescription drugs or medicine;

(C) dental services;

(D) the facility services of a hospital or other health care facility; and

(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

(2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.

(3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

(4) For workers' compensation specific codes, services and programs provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.

(5) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(b) Payment Policies Relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:

(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, Division-specific modifiers are identified in subsection (n) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

(3) Incentive Payments. A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (d), (e), (g), (i), (j), and (k) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(d) When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title (relating to Medical Reimbursement).

(e) Case Management Responsibilities by the Treating Doctor is as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

(A) Team members shall not be employees of the treating doctor.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone 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.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

(B) developing or revising a treatment plan, including any treatment plans required by Division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity.

(B) CPT Code 99362.

(i) Reimbursement to the treating doctor shall be $198. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $50 when a HCP contributes to the case management activity.

(C) CPT Code 99371.

(i) Reimbursement to the treating doctor shall be $18. Modifier "W1" shall be added.

(ii) Reimbursement to a referral HCP contributing to this case management activity shall be $5.

(D) CPT Code 99372.

(i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management activity shall be $12.

(E) CPT Code 99373.

(i) Reimbursement to the treating doctor shall be $90. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management action shall be $23.

(f) To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

(g) The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division 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:

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

(A) appearance (observational and palpation);

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

(C) posture and deformities;

(D) vascular integrity;

(E) neurological tests to detect sensory deficit;

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

(G) reflexes to detect neurological reflex symmetry.

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

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

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

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

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

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

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

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

(h) The following shall be applied to Return To Work Rehabilitation Programs 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 Division 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, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

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

(A) 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 percent of the MAR.

(B) 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 percent of the MAR.

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

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

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

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one 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.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 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.

(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 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.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(i) The following shall apply to Designated Doctor Examinations.

(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows:

(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6;"

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W7;"

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W8"; and

(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W9."

(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;

(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and

(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

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

(1) 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:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) 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,

(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

(2) An 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 Division rules in Chapter 130 of this title.

(A) 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 paragraph (3) of this subsection. Modifier “NM” shall be added.

(B) 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 paragraph (3) of this subsection.

(C) 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 paragraphs (3) and (4) of this subsection.

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

(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 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.

(B) 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 paragraph (3)(A) of this subsection; or,

(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

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

(A) 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.

(B) 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.

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

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

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

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

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

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

(-b-) $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 percent of the total MAR.

(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength 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 percent of the total MAR.

(v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

(D) 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:

(I) body systems;

(II) body structures (including skin); and,

(III) 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:

(I) 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 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

(II) 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.

(iv) When there is no test to determine an IR for a non-musculoskeletal condition:

(I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.

(II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.

(III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

(5) 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 paragraphs (3) and (4) of this subsection.

(6) 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 Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.

(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

(l) The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).

(m) The following shall apply to Treating Doctor Examination to Define the Compensable Injury. When billing for this type of examination, refer to §126.14 of this title (relating to Treating Doctor Examination to Define Compensable Injury).

(n) The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.

(1) 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.

(2) CP, Chronic Pain Management Program - This modifier shall be added to CPT Code 97799 to indicate Chronic Pain Management Program services were performed.

(3) FC, Functional Capacity - This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed.

(4) MR, Outpatient Medical Rehabilitation Program - This modifier shall be added to CPT Code 97799 to indicate Outpatient Medical Rehabilitation Program services were performed.

(5) MI, Multiple Impairment Ratings – This modifier shall be added to CPT Code 99455 when the designated doctor is required to complete multiple impairment ratings calculations.

(6) 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.

(7) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC) - This modifier shall be added to CPT Code 99456 when a RTW or EMC examination is performed.

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

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

(10) VR, Review report - This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor’s review of report(s) only.

(11) V1, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to a “minimal” level.

(12) V2, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to “self limited or minor” level.

(13) V3, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to “low to moderate” level.

(14) V4, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to “moderate to high severity” level and of at least 25 minutes duration.

(15) V5, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to “moderate to high severity” level and of at least 45 minutes duration.

(16) WC, Work Conditioning - This modifier shall be added to CPT Code 97545 to indicate work conditioning was performed.

(17) WH, Work Hardening - This modifier shall be added to CPT Code 97545 to indicate work hardening was performed.

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

(19) W1, Case Management for Treating Doctor - This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.

(20) W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement – This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.

(21) W6, Designated Doctor Examination for Extent - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee’s compensable injury.

(22) W7, Designated Doctor Examination for Disability - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee’s disability is a direct result of the work-related injury.

(23) W8, Designated Doctor Examination for Return to Work - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.

(24) W9, Designated Doctor Examination for Other Similar Issues - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.

The provisions of this §134.204 adopted to be effective January 17, 2008, 33 TexReg 428; amended to be effective March 1, 2008, 33 TexReg 626.

§134.302. Dental Fee Guideline.

(a) Dental services rendered under the Texas Workers' Compensation Act shall include the repair or replacement of those teeth and oral structures injured or directly affected by an occupational injury or disease. This guideline is effective for dental services provided after the effective date of this rule. Dental services provided prior to the effective date of this rule shall be subject to the 1992 Dental Guideline. Preauthorization of any treatments or services shall be as required in the Commission's preauthorization rule.

(b) The coding for dental services shall be the most recent Current Dental Terminology (CDT) of the American Dental Association with the modifier "DS" listed before each CDT code.

(c) Reimbursement for services rendered shall be a fair and reasonable rate. Reimbursement is allowed only when a licensed dentist is performing compensable services within the dentist's scope of practice or when a nonlicensed individual is rendering care under the direct supervision of a licensed dentist.

(d) Examples of services which are not covered by workers' compensation insurance include:

(1) all preventative services;

(2) multiple units of fixed prosthetics exceeding the number of teeth involved in the original injury, except necessary abutments and/or implants;

(3) hair and tissue analysis;

(4) treatments based on mercury toxicity;

(5) silent period durations;

(6) jaw tracking not induced by trauma; and

(7) mandibular kinesiography not induced by trauma.

(e) If multiple procedures are performed during the same operative session, then the following rule for reimbursement applies:

(1) reimbursement for the primary procedure is 100% of the fair and reasonable value for the major procedure; and

(2) reimbursement for the secondary procedure(s) is 50% of the fair and reasonable value for the secondary procedure(s).

(f) Reimbursement for laboratory procedures performed in dental laboratories are included in the reimbursement for the dental procedure code(s).

The provisions of this §134.302 adopted to be effective December 1, 1996, 21 TexReg 10436.

§134.303 2005 Dental Fee Guideline

(a) Applicability of this rule is as follows:

(1) This section applies to professional dental services provided in the Texas Workers' Compensation system.

(2) This section shall be applicable to professional dental services provided on or after June 15, 2005. For professional dental services provided August 1, 2003 through June 14, 2005, §134.202 of this title (relating to Medical Fee Guideline) shall be applicable. For professional dental services provided December 1, 1996 through July 31, 2003, §134.302 of this title (relating to Dental Fee Guideline) shall be applicable.

(3) 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 provision adopted by or utilized by Texas Medicaid in administering the Texas Medicaid Dental Fee Schedule. 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.

(4) Whenever a component of the Texas Medicaid Dental Fee Schedule 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 dental treatments and services, Texas Workers' Compensation system participants shall apply the Texas Medicaid Dental Fee Schedule 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), the following apply:

(1) The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%.

(2) For products and services for which the Texas Medicaid Dental Fee Schedule does not establish a value, 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) Reimbursement for dental laboratory procedures is bundled with the maximum fees for the associated dental procedures. No additional reimbursement shall be due.

(e) In all cases, reimbursement shall be the lesser of the:

(1) MAR amount;

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

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

The provisions of this §134.303 adopted to be effective June 9, 2005, 30 TexReg 3232.

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SUBCHAPTER E. HEALTH FACILITY SERVICES

§134.402. Ambulatory Surgical Center Fee Guideline.

(a) Applicability of this rule is as follows:

(1) This section applies to facility services provided on or after September 1, 2008 by an ambulatory surgical center (ASC), other than professional medical services.

(2) This section does not apply to:

(A) professional medical services billed by a health care provider not employed by the ASC, except for a surgical implant provider as described in this section; or

(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(1) "Ambulatory Surgical Center" means a health care facility appropriately licensed by the Texas Department of State Health Services.

(2) "ASC device portion" means the portion of the ASC payment rate that represents the cost of the implantable device, and is calculated by applying the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) device offset percentage to the OPPS payment rate.

(3) "ASC service portion" means the Medicare ASC payment rate less the device portion.

(4) "Device intensive procedure" means an ASC covered surgical procedure that has been designated by CMS as device intensive in TABLE 56 – ASC COVERED SURGICAL PROCEDURES DESIGNATED AS DEVICE INTENSIVE FOR CY 2008 or its successor.

(5) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program, and recharge the implantable.

(6) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(7) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133.

(d) For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) 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 and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply:

(1) Reimbursement for non-device intensive procedures shall be:

(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or

(B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:

(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and

(ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

(2) Reimbursement for device intensive procedures shall be:

(A) the sum of:

(i) the ASC device portion; and

(ii) the ASC service portion multiplied by 235 percent; or

(B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:

(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and

(ii) the ASC service portion multiplied by 235 percent.

(g) A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable.

(1) The facility or surgical implant provider requesting reimbursement for the implantable shall:

(A) bill for the implantable on the Medicare-specific billing form for ASCs;

(B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.

(2) An insurance carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes an ASC or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) For medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

(i) If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

(1) The agreement may occur before, or during, preauthorization.

(2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

(3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) any other provisions of the agreement; and

(C) names, titles and signatures of both parties with dates.

(4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(5) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

(j) 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.

*The provisions of this §134.402 adopted to be effective May 9, 2004, 29 TexReg 4223. (*applicable to facility services provided by an Ambulatory Surgical Center on or after September 1, 2004.); *amended to be effective March 10, 2005, 30 Tex Reg 1290; amended to be effective December 30, 2007, 32 TexReg 9696; amended to be effective August 31, 2008, 33 TexReg 6830.*

§134.403. Hospital Facility Fee Guideline – Outpatient.

(a) Applicability of this section is as follows.

(1) This section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008.

(2) This section does not apply to:

(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or

(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

(2) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program and recharge the implantable.

(3) “Medicare payment policy” means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(4) “Outpatient” means the patient is not admitted for inpatient or residential care. Outpatient medical services includes observation in an outpatient status provided the observation period complies with Medicare policies.

(5) “Surgical implant provider” means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits – Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers’ Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) 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 and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this tile (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B).

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

The provisions of this §134.403 adopted to be effective January 17, 2008, 33 TexReg 428; amended to be effective March 1, 2008, 33 TexReg 626.

§134.404. Hospital Facility Fee Guideline – Inpatient.

(a) Applicability of this section is as follows.

(1) This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.

(2) For admission dates prior to March 1, 2008, the law and Division of Workers' Compensation (Division) rules in effect for those dates of service shall apply.

(3) This section does not apply to:

(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or

(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

(2) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program and recharge the implantable.

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(4) “Outlier payment amount” means the amount determined through use of the calculations described in subsection (f).

(5) “Surgical implant provider” means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits – Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers’ Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) 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 and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) A hospital that is classified by Medicare as a Sole Community Hospital, a Medicare Dependent Hospital, or a Rural Referral Center Hospital, shall initially be paid the amount calculated for such hospital in accordance with subsections (e) through (g) of this section. If the initial payment is less than the cost of the services in question, the hospital may request reconsideration in accordance with §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) and present documentation of any amount it would have been paid under the Medicare regulations in effect when the services were performed. If such a showing is made, the hospital shall be paid the difference between the amount initially paid and the amount Medicare would have paid for the services as adjusted by the appropriate multiplier.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

The provisions of this §134.404 adopted to be effective January 17, 2008, 33 TexReg 428; amended to be effective March 1, 2008, 33 TexReg 626.

SUBCHAPTER F – PHARMACEUTICAL BENEFITS

§134.500. Definitions.

(a) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Compounding--The combining of a drug with one or more drugs or substances (other than water) as a result of a prescription.

(2) Statement of Medical Necessity--A written statement and supporting documentation from the prescribing doctor to establish the need for treatments or services, or prescriptions, including the need for a brand name drug where applicable. A statement of medical necessity includes the employee's full name, date of injury, social security number or TWCC claim number, and how the services, or prescriptions treat the diagnosis, promote recovery, or enhance the ability of the employee to return to or retain employment.

(3) Nonprescription drug or over-the-counter medication--A non-narcotic drug that may be sold without a prescription and that is labeled and packaged in compliance with state or federal law.

(4) Open formulary--Includes all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs, but does not include drugs that lack FDA approval, or non-drug items.

(5) Prescribing doctor--a doctor who prescribes prescription drugs or over the counter medications in accordance with the doctor's license and state and federal laws and rules.

(6) Prescription--An order from a doctor for a prescription or nonprescription drug to be dispensed.

(7) Prescription drug --

(A) A substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public;

(B) A drug that under federal law is required, before being dispensed or delivered, to be labeled with the statement, " Caution: federal law prohibits dispensing without prescription"; or,

(C) A drug that is required by federal or state statute or regulation to be dispensed on prescription or that is restricted to use by a prescribing doctor only.

(b) Section 134, Subchapter F applies to all prescriptions that are prescribed or filled on or after March 1, 2002. For prescriptions filled before March 1, 2002 §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) shall be applicable.

The provisions of this §134.500 adopted to be effective January 3, 2002, 26 TexReg 10970.

§134.501. Initial Pharmaceutical Coverage.

(a) For injuries which occur on or after December 1, 2002, the insurance carrier (carrier) shall pay for specified pharmaceutical services sufficient for the first seven days following the date of injury, regardless of issues of liability for or compensability of the injury that the carrier may have, if, prior to providing the pharmaceutical services, the health care provider (HCP) obtains both a verification of insurance coverage, and an oral or written confirmation that an injury has been reported. For purposes of this rule, specified pharmaceutical services are prescription drugs and over-the-counter medications prescribed by a doctor that cure or relieve the effects naturally resulting from the compensable injury, promote recovery, or enhance the ability of the employee to return to or retain employment.

(1) In determining the first seven days following the injury, the date of the injury is not counted. The first day after the date of injury shall be counted as "day one." The last day of the seven-day period shall be known as "day seven."

(2) If the pharmaceutical services are provided after day one, the carrier's reimbursement under this section is limited to the date the pharmaceutical services were actually provided through day seven. (Example: The pharmaceutical services were provided on day four. The carrier's liability for payment under this section would be for pharmaceutical services in an amount prescribed that would be the quantity sufficient for days four, five, six and seven.)

(3) Payment for the specified pharmaceutical services for the first seven days following the date of injury shall be in accordance with §134.503 of this title (relating to Reimbursement Methodology). The dispensing fee for the initial prescription shall not be denied, prorated, or reduced even if the HCP provided pharmaceutical services beyond the first seven days following the date of injury and the carrier disputes or denies the pharmaceutical services beyond the first seven days following the date of injury.

(b) The carrier may be eligible for reimbursement from the subsequent injury fund (SIF) for payments made under subsection (a) as provided in Chapter 116 of this title.

(c) The HCP can verify insurance coverage and confirm the existence of a report of an injury by calling the employer or the carrier. Upon request, the employer and/or the carrier shall verify coverage and confirm any report of an injury. For verifying insurance coverage, the HCP can also review the commission's internet-based coverage verification system.

(1) The HCP shall document verifications and confirmations not obtained in writing by indicating how the verification or confirmation was obtained (date obtained, from whom, etc.).

(2) The HCP shall affirm on the bill for the pharmaceutical services, in the form and manner prescribed by the commission, that the HCP verified that there is insurance coverage and confirmed that an injury has been reported.

(d) Notwithstanding any other provision of this section, the HCP may dispense prescription or nonprescription medications in the amount ordered by the prescribing doctor in accordance with applicable state and federal law (not to exceed the limits imposed by §134.502 of this title (relating to Pharmaceutical Services)).

(e) The HCP and carrier may voluntarily discuss approval of pharmaceutical services beyond the seven days following the date of injury as provided in Texas Labor Code §413.014(e) and §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

(f) Communication is important to ensure prompt delivery of pharmaceutical services.

(1) Injured employees (employees) are encouraged to immediately report their injury to their employer.

(2) Employees are encouraged to ask for, and employers to provide, a written statement that confirms an injury was reported to the employer and identifies the date of injury (as reported by the employee) and the employer's insurance carrier. Verifying that there is insurance coverage and/or confirming that an injury was reported does not waive the employer's right to contest compensability under Texas Labor Code §409.011 should the carrier accept liability for the payment of benefits.

(3) The carrier's verification of coverage and/or confirmation of a reported injury does not waive the insurance carrier's right to further review the claim under Texas Labor Code §409.021 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute).

The provisions of this §134.501 adopted to be effective November 7, 2002, 27 TexReg 10391.

§134.502 Pharmaceutical Services.

(a) A doctor providing care to an injured employee shall prescribe for the employee medically necessary prescription drugs and over-the-counter medication (OTC) alternatives as clinically appropriate and applicable in accordance with applicable state law and as provided by this section.

(1) It shall be indicated on the prescription that the prescription is related to a workers' compensation claim.

(2) When prescribing an OTC medication alternative to a prescription drug, the doctor shall indicate on the prescription the appropriate strength of the medication and the approximate quantity of the OTC medication that is reasonably required by the nature of the compensable injury.

(3) The doctor shall prescribe generic prescription drugs when available and clinically appropriate. If in the medical judgment of the prescribing doctor a brand-name drug is necessary, the doctor must specify on the prescription that brand-name drugs be dispensed in accordance with applicable state and federal law, and must maintain documentation justifying the use of the brand-name drug, in the patient's medical record.

(4) The doctor shall prescribe OTC medications in lieu of a prescription drug when clinically appropriate.

(b) When prescribing, the doctor shall choose medications and drugs from the formulary adopted by the commission.

(c) The pharmacist shall dispense no more than a 90-day supply of a prescription drug.

(d) Pharmacists shall submit bills for pharmacy services in accordance with §134.800(d) of this title (relating to Required Billing Forms and Information).

(1) Health care providers shall bill using national drug codes (NDC) when billing for prescription drugs.

(2) Compound drugs shall be billed by listing each drug included in the compound and calculating the charge for each drug separately.

(3) A pharmacy may contract with a separate person or entity to process bills and payments for a medical service; however, these entities are subject to the direction of the pharmacy and the pharmacy is responsible for the acts and omissions of the person or entity. Except as allowed by Texas Labor Code §413.042, the injured employee shall not be billed for pharmacy services.

(e) The carrier, employee, or pharmacist may request a statement of medical necessity from the prescribing doctor. If a carrier requests a statement of medical necessity, the carrier shall provide the sender of the bill a copy of the request at the time the request is made. A carrier shall not request a statement of medical necessity unless in the absence of such a statement the carrier could reasonably support a denial based upon extent of, or relatedness to the compensable injury, or based upon reasonableness or medical necessity.

(f) The prescribing doctor shall provide a statement of medical necessity to the requesting party no later than the 14th working day after receipt of request. The prescribing doctor shall not bill for nor shall the carrier reimburse for the statement of medical necessity.

(g) In addition to the requirements of §133.304, (relating to Medical Payments and Denials) regarding explanation of benefits (EOB), at the time an insurance carrier denies payment for medications for any reason related to compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons related to reasonableness or medical necessity, the carrier shall also send the EOB to the employee, and the prescribing doctor.

The provisions of this §134.502 adopted to be effective January 3, 2002, 26 TexReg 10970; amended to be effective January 1, 2003, 27 TexReg 12353.

§134.503. Reimbursement Methodology.

(a) The maximum allowable reimbursement (MAR) for prescription drugs shall be the lesser of:

(1) The provider's usual and customary charge for the same or similar service;

(2) The fees established by the following formulas based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical reimbursement system (e.g. Redbook, First Data Bank Services) in effect on the day the prescription drug is dispensed.

(A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee = MAR;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee = MAR;

(C) A compounding fee of $15 per compound shall be added for compound drugs; or

(3) A negotiated or contract amount.

(b) When the doctor has written a prescription for a generic drug or a prescription that does not require the use of a brand name drug in accordance with §134.502(a)(3), reimbursement shall be as follows:

(1) the pharmacist shall dispense the generic drug as prescribed and shall be reimbursed the fee established for the generic drug in accordance with subsection (a) of this section; or

(2) when an injured employee chooses to receive a brand name drug instead of the prescribed generic drug, the pharmacist shall dispense the brand name drug as requested and shall be reimbursed:

(A) by the insurance carrier, the fee established for the prescribed generic drug in accordance with subsection (a) of this section; and

(B) by the employee, the cost difference between the fee established for the generic drug and the fee established for the brand name drug in accordance with §134.503(a)(2) of this title.

(c) When the doctor has written a prescription for a brand name drug in accordance with §134.502(a)(3), reimbursement shall be in accordance with subsection (a) of this section.

(d) Reimbursement for over-the-counter medications shall be the retail price of the lowest package quantity reasonably available that will fill the prescription.

(e)This section applies to the dispensing of all drugs except inpatient drugs and parenteral drugs.

(f) Upon request by the provider, the insurance carrier shall disclose the source of the AWP used.

The provisions of this §134.503 adopted to be effective January 3, 2002, 26 TexReg 10970; amended to be effective March 14, 2004, 29 TexReg 2346.

§134.504. Pharmaceutical Expenses Incurred by the Injured Employee.

(a) It may become necessary for an injured employee to purchase prescription drugs or over-the-counter alternatives to prescription drugs prescribed or ordered by the treating doctor or referral health care provider. In such instances the injured employee may request reimbursement from the insurance carrier as follows:

(1) The injured employee shall submit to the insurance carrier a letter requesting reimbursement along with a receipt indicating the amount paid and documentation concerning the prescription. The letter should include information to clearly identify the claimant such as the claimant's name, address, date of injury, and social security number. Documentation for prescription drugs submitted with the letter from the employee must

include the prescribing health care provider's name, the date the prescription was filled, the name of the drug, employee's name and dollar amount paid by the employee. As examples, this information may be provided on an information sheet provided by the pharmacy, or the employee can ask the pharmacist for a print out of work related prescriptions for a particular time period. Cash register receipts alone are not acceptable.

(2) The insurance carrier shall make appropriate payment to the injured employee in accordance with §134.503, or notify the injured employee of a reduction or denial of the payment within 45 days of receipt of the request for reimbursement from the injured employee. If the insurance carrier does not reimburse the full amount requested, or denies payment the carrier shall include a full and complete explanation of the reason(s) the insurance carrier reduced or denied the payment and shall inform the injured employee of his or her right to request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution). The statement shall include sufficient claim-specific substantive information to enable the employee to understand the insurance carrier's position and/or action on the claim. A general statement that simply states the carrier's position with a phrase such as "not entitled to reimbursement" or a similar phrase with no further description of the factual basis does not satisfy the requirements of this section.

(b) An injured employee may choose to receive a brand name drug rather than a generic drug or over-the-counter alternative to a prescription medication that is prescribed by a health care provider. In such instances, the injured employee shall pay the difference in cost between generic drugs and brand name drugs. The transaction between the employee and the pharmacist is considered final and is not subject to medical dispute resolution by the Commission. In addition, the employee is not entitled to reimbursement from the insurance carrier for the difference in cost between generic and brand name drugs.

(1) The injured employee shall notify the pharmacist of their choice to pay the cost difference between generic and brand name drugs. An employee's payment of the cost difference constitutes an acceptance of the responsibility for the cost difference and an agreement not to seek reimbursement from the carrier for the cost difference.

(2) The pharmacist shall:

(A) determine the costs of both the brand name and generic drugs by using the reimbursement formulas stated in §134.503(a)(2), and notify the injured employee of the cost difference amount;

(B) collect the cost difference amount from the injured employee in a form and manner that is acceptable to both parties;

(C) submit a bill to the insurance carrier for the generic drug that was prescribed by the doctor; and

(D) not bill the injured employee for the cost of the generic drug if the insurance carrier reduces or denies the bill.

(3) The insurance carrier shall review and process the bill from the pharmacist in accordance with Chapter 133 and 134 (pertaining to General Medical Provisions and Benefits-Guidelines for Medical Services, Charges, and Payment, respectively.)

The provisions of this §134.504 adopted to be effective January 3, 2002, 26 TexReg 10970; amended to be effective March 14, 2004, 29 TexReg 2346.

§134.506. Outpatient Drug Formulary.

The commission hereby adopts an open formulary as defined in §134.500(a)(4). The carrier shall pay for drugs that are reasonable and medically necessary to treat the compensable injury or occupational disease including prescriptions for off label indications when used in accordance with current medical standards and prescribed in compliance with published contradictions, precautions, and warnings. Over-the-counter medications with a prescription shall be reimbursed in accordance with §134.503 (relating to Reimbursement Methodology).

The provisions of this §134.506 adopted to be effective January 3, 2002, 26 TexReg 10970.

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SUBCHAPTER G. PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE

§134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

(1) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care.

(2) Concurrent review: a review of on-going health care listed in subsection (q) of this section for an extension of treatment beyond previously approved health care listed in subsection (p) of this section.

(3) Diagnostic study: any test used to help establish or exclude the presence of disease/injury in symptomatic persons. The test may help determine the diagnosis, screen for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis.

(4) Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the Division from preauthorization and concurrent review requirements.

(5) Final adjudication: the Commissioner has issued a final decision or order that is no longer subject to appeal by either party.

(6) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care.

(7) Preauthorization: prospective approval obtained from the insurance carrier (carrier) by the requestor or injured employee (employee) prior to providing the health care treatment or services (health care).

(8) Requestor: the health care provider or designated representative, including office staff or a referral health care provider/health care facility that requests preauthorization, concurrent review, or voluntary certification.

(9) Work conditioning and work hardening: return to work rehabilitation programs as defined in Chapter 134 of this title (relating to Benefits – Guidelines for Medical Service, Charges and Payments).

(b) When Division-adopted treatment guidelines conflict with this section, this section prevails.

(c) The carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or

(D) when ordered by the Commissioner; or (2) per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

(d) The carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

(e) The carrier shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requestor or employee to request preauthorization or concurrent review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to by the carrier within the time limits established in subsection (i) of this section.

(f) The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the:

(1) specific health care listed in subsection (p) or (q) of this section;

(2) number of specific health care treatments and the specific period of time requested to complete the treatments;

(3) information to substantiate the medical necessity of the health care requested;

(4) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the carrier;

(5) name of the provider performing the health care; and

(6) facility name and estimated date of proposed health care.

(g) A health care provider may submit a request for health care to treat an injury or diagnosis that is not accepted by the carrier in accordance with Labor Code §408.0042.

(1) The request shall be in the form of a treatment plan for a 60 day timeframe.

(2) The carrier shall review requests submitted in accordance with this subsection for both medical necessity and relatedness.

(3) If denying the request, the carrier shall indicate whether the denial is based on medical necessity and/or unrelated injury/diagnosis in accordance with subsection (m).

(4) The requestor or employee may file an extent of injury dispute upon receipt of a carrier's response which includes a denial due to unrelated injury/diagnosis, regardless of the issue of medical necessity.

(5) Requests which include a denial due to unrelated injury/diagnosis may not proceed to medical dispute resolution based on the denial of unrelatedness. However, requests which include a denial based on medical necessity may proceed to medical dispute resolution for the issue of medical necessity in accordance with subsection (o).

(h) Except for requests submitted in accordance with subsection (g) of this section, the carrier shall approve or deny requests based solely upon the medical necessity of the health care required to treat the injury, regardless of:

(1) unresolved issues of compensability, extent of or relatedness to the compensable injury;

(2) the carrier's liability for the injury; or

(3) the fact that the employee has reached maximum medical improvement.

(i) The carrier shall contact the requestor or employee by telephone, facsimile, or electronic transmission with the decision to approve or deny the request as follows:

(1) within three working days of receipt of a request for preauthorization; or

(2) within three working days of receipt of a request for concurrent review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(j) The carrier shall send written notification of the approval or denial of the request within one working day of the decision to the:

(1) employee;

(2) employee's representative; and

(3) requestor, if not previously sent by facsimile or electronic transmission.

(k) The carrier's failure to comply with any timeframe requirements of this section shall result in an administrative violation.

(l) The carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:

(1) the specific health care;

(2) the approved number of health care treatments and specific period of time to complete the treatments; and

(3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury.

(m) The carrier shall afford the requestor a reasonable opportunity to discuss the clinical basis for a denial with the appropriate doctor or health care provider performing the review prior to the issuance of a preauthorization or concurrent review denial. The denial shall include:

(1) the clinical basis for the denial;

(2) a description or the source of the screening criteria that were utilized as guidelines in making the denial;

(3) the principle reasons for the denial, if applicable;

(4) a plain language description of the complaint and appeal processes, if denial was based on Labor Code §408.0042, include notification to the injured employee and health care provider of entitlement to file an extent of injury dispute in accordance with Chapter 141 of this title (relating to Dispute Resolution—Benefit Review Conference); and

(5) after reconsideration of a denial, the notification of the availability of an independent review.

(n) The carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and carrier and is documented.

(o) If the initial response is a denial of preauthorization, the requestor or employee may request reconsideration. If the initial response is a denial of concurrent review, the requestor may request reconsideration.

(1) The requestor or employee may within 15 working days of receipt of a written initial denial request the carrier to reconsider the denial and shall document the reconsideration request.

(2) The carrier shall respond to the request for reconsideration of the denial:

(A) within five working days of receipt of a request for reconsideration of denied preauthorization; or

(B) within three working days of receipt of a request for reconsideration of denied concurrent review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request;

(3) The requestor or employee may appeal the denial of a reconsideration request regarding medical necessity by filing a dispute in accordance with Labor Code §413.031 and related Division rules.

(4) A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the employee's medical condition. The carrier shall review the documentation and determine if a substantial change in the employee's medical condition has occurred.

(p) Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all non-exempted work hardening or non-exempted work conditioning programs;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury, or

(ii) a surgical intervention previously preauthorized by the carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee guideline, or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the Division's formulary;

(12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier;

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(q) The health care requiring concurrent review for an extension for previously approved services includes:

(1) inpatient length of stay;

(2) all non-exempted work hardening or non-exempted work conditioning programs;

(3) physical and occupational therapy services as referenced in subsection (p)(5) of this section;

(4) investigational or experimental services or use of devices;

(5) chronic pain management/interdisciplinary pain rehabilitation; and

(6) required treatment plans.

(r) The requestor and carrier may voluntarily discuss health care that does not require preauthorization or concurrent review under subsections (p) and (q) of this section respectively.

(1) Denial of a request for voluntary certification is not subject to dispute resolution for prospective review of medical necessity.

(2) The carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective review of medical necessity.

(3) If there is no agreement between the carrier and requestor, health care provided is subject to retrospective review of medical necessity.

(s) An increase or decrease in review and preauthorization controls may be applied to individual doctors or individual workers' compensation claims, by the Division in accordance with Labor Code §408.0231(b)(4) and other sections of this title.

(t) The carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent review approval/denial decisions, and appeals, if any. The carrier shall also maintain accurate records to reflect information regarding requests for voluntary certification approval/denial decisions. Upon request of the Division, the carrier shall submit such information in the form and manner prescribed by the Division.

The provisions of this §134.600 adopted to be effective December 23, 1991, 16 TexReg 7099; amended to be effective April 1, 1997, 22 TexReg 1317; amended to be effective January 1, 2002, 26 TexReg 9874; amended to be effective January 1, 2003, 27 TexReg 12359; amended to be effective March 14, 2004, 29 TexReg 2360; amended to be effective May 2, 2006, TexReg 31 TexReg 3566.

SUBCHAPTER I. MEDICAL BILL REPORTING

§134.802. Insurance Carrier Medical Electronic Data Interchange to the Division.

(a) The insurance carrier shall submit medical bill and payment data to the Division within 30 days after the insurance carrier makes payment, denies payment, or receives a refund of overpayment on a medical bill.

(b) Insurance carriers shall submit medical bill and payment data electronically in the form and format prescribed by the Division.

(c) The Division shall prescribe the form, format, and content of the required medical bill and payment data submission.

(d) This section shall apply to all dates of service on or after July 15, 2000, for facility and professional medical services except pharmacy and dental services.

(e) This section shall apply to all dates of service on or after January 1, 2005, for pharmacy and dental services in addition to the already required facility and professional medical services.

The provisions of this §134.802 adopted to be effective February 20, 1991, 16 TexReg 671; amended to be effective June 1, 1992, 17 TexReg 3250; amended to be effective December 1, 1992, 17 TexReg 7903; amended to be effective July 15, 2000, 25 TexReg 2139; amended to be effective July 11, 2004, 29 TexReg 6303; amended to be effective May 1, 2005, 30 TexReg 2398; amended to be effective May 2, 2006, 31 TexReg 3561.

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SUBCHAPTER J - REVIEWS AND AUDITS

§134.900. Medical Benefit Review and Audit.

(a) The division of medical review (the division) shall review and audit medical services, to include, but not be limited to:

(1) treatments administered;

(2) services provided;

(3) fees charged;

(4) payments made for medical treatment or services provided to injured employees; and

(5) compliance with other commission rules regulating health care.

(b) The division may conduct a review or audit at the office of an insurance carrier, third party administrator, audit company, health care provider, or at any other appropriate location as determined by the division.

(c) The division shall notify, in writing, the person or entity whose documents are to be reviewed and audited, stating when the review and audit will be performed and the commission employee to contact.

(d) The division shall be granted access to documents and to information regarding health care treatment; fees charged; or payments made, modified, or denied. Pursuant to law, failure or refusal to comply with a division request or order for any information is an administrative violation subject to penalty as provided by the Act.

(e) The person or entity being reviewed or audited by the division shall furnish division personnel, for the duration of the review and audit, with:

(1) a contact person to answer questions and respond to the needs of division staff;

(2) office space;

(3) access to a copy machine; and

(4) access to a telephone.

(f) The commission shall charge a reasonable administrative fee, set in accordance with Administrative Procedure 5, for the review and audit conducted under this rule.

(g) The intensity of review and audit for compliance with medical policies and fee guidelines shall be increased as necessary to induce compliance by the health care provider who has established practices and patterns in medical charges or treatments inconsistent with medical policies and guidelines established by the commission.

(h) Reports of all probable violations of law and commission rules found during a review and audit shall be forwarded to the division of compliance and practices.

The provisions of this §134.900 adopted to be effective October 1, 1992, 17 TexReg 6364.

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