

**RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-02-17
RULES FOR MEDICAL PAYMENTS**

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0800-02-17-.01 PURPOSE AND SCOPE.

(1) Purpose:

Pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005), this chapter, together with the Medical Fee Schedule Rules, Chapter 0800- 02-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19-.01 et seq., (collectively hereinafter "Rules") are hereby adopted by the Administrator in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of bills, enforcement procedures and appeal hearings. The Administrator promulgates these Rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). This chapter must be used in conjunction with the Medical Fee Schedule Rules (Chapter 0800-02-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19). The Rules establish maximum allowable fees and procedures for all medical care and services provided to any employee claiming medical benefits under the Tennessee Workers' Compensation Act. Employers and providers may negotiate and contract or pay lesser fees as are agreeable between them, but in no event shall reimbursement be in excess of the Rules, subject to the civil penalties prescribed in the Rules, as assessed by, and in the discretion of, the Administrator, the Administrator's designee, or an agency member appointed by the Administrator. These Rules are applicable only to those injured employees claiming benefits under the Tennessee Workers' Compensation Act.

(2) Scope: These rules do all of the following:

- (a) Establish procedures by which the employer shall furnish, or cause to be furnished to an employee who sustains a personal injury, illness, or occupational disease, reasonable and necessary medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when

(Rule 0800-02-17-.01, continued)

needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to treat, so far as reasonably and necessarily possible, and provide relief from the effects of that injury or occupational disease.

- (b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
- (c) Establish procedures by which a health care provider shall be paid the lesser of: (1) the provider's usual bill, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted or lower price, where applicable. Unless authorized by the administrator, in no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the Administrator's discretion, result in civil penalties of not less than fifty dollars (\$50) nor greater than five thousand dollars (\$5,000.00) per violation each assessed severally against the provider accepting such fee and the employer paying the excessive fee, if a pattern or practice of such activity is found. At the Administrator's discretion, multiple violations by a provider may subject the provider to exclusion from further participating in providing medical care to injured workers under the Act.
- (d) Identify utilization of health care and health services which is above the usual range of utilization for such services, based on medically accepted standards. Also to provide the ability by an employer and the Bureau to obtain necessary records, medical bills, and other information concerning any health care or health service under review.
- (e) Establish a system for the evaluation by an employer of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.
- (f) Permit review by the Bureau of the records and medical bills of any health facility or health care provider to determine whether or not they are in compliance with these Rules, or which may be requiring unjustified and/or unnecessary treatment, hospitalization or office visits or other healthcare services.
- (g) Provide for deposition and witness fees.
- (h) Establish maximum fees for medical reports.
- (i) Provide for uniformity of billing for provider services.
- (j) Establish the effective date for implementation of these Rules. Adopt by reference as part of these Rules the International Classification of Diseases, ICD-9-CM and ICD-10-CM, the American Medical Association's CPT® and Center for Medicare and Medicaid Services (CMS-Medicare) guidelines, Medical Fee Schedule Rules (Chapter 0800-02-18), the In-patient Hospital Fee Schedule (Chapter 0800-02-19) and any amendments to them.
- (k) Establish procedures for reporting of medical claims.
- (l) Establish procedures for pre-authorization of non-emergency hospitalizations, transfers between facilities, and outpatient services.
- (m) Establish procedures for imposing and collecting civil penalties for violations of these Rules.

(Rule 0800-02-17-.01, continued)

- (n) These rules shall apply where appropriate in conjunction with electronic submission of payments (e-billing).

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-125, 50-6-128, 50-6-202, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.02 RESERVED.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.03 DEFINITIONS.

The following definitions are for the purposes of and are applicable to the Rules for Medical Payments (Chapter 0800-02-17), the Medical Fee Schedule Rules (Chapter 0800-02-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19):

- (1) "Act" means Tennessee's Workers' Compensation Act, Tenn. Code Ann. §§ 50-6-101 et seq. as currently enacted by the Tennessee General Assembly, specifically including any future enactments by the Tennessee General Assembly involving amendments, deletions, additions, repeals, or any other modification, in any form of the Workers' Compensation Act.
- (2) "Adjust" means that an employer changes a health care provider's request for payment, including but not limited to:
 - (a) Applies the maximum fee allowable under these Rules;
 - (b) Applies an agreed upon discount to the provider's usual bill, in accordance with the requirement in T.C.A. § 50-6-215;
 - (c) Adjusts to a usual and customary amount when the maximum fee is by report;
 - (d) Reduces or denies all or part of a properly-submitted bill for payment as a result of bill review;
 - (e) Recodes a procedure.
- (3) "Administrator" means the chief administrative officer of the Bureau of Workers' Compensation or the Administrator's designee.
- (4) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place as determined by the Administrator or the Administrator's designee after consultation with the Medical Director.
- (5) "Bill" means a request by a provider submitted to an employer for payment for health care services provided in connection with a compensable injury, illness or occupational disease.
- (6) "BR" (By Report) means that the procedure is not assigned a maximum fee and requires a written description. The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:

(Rule 0800-02-17-.03, continued)

- (a) Copies of operative reports;
 - (b) Consultation reports;
 - (c) Progress note;
 - (d) Office notes or other applicable documentation;
 - (e) Description of equipment or supply (when that is the bill).
- (7) "Bureau" means the Tennessee Bureau of Workers' Compensation as defined in T.C.A. § 50-6-102, an autonomous unit attached to the Tennessee Department of Labor and Workforce Development for administrative matters only pursuant to T.C.A. § 4-3-1409.
- (8) "Case" means a compensable injury, illness or occupational disease identified by the worker's name and date of injury, illness or occupational disease.
- (9) "CMS" means the U.S. Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration). The rules promulgated by CMS used in these chapters are referred to as "Medicare".
- (10) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately, as defined by Medicare.
- (11) "Consultant service" means; in regard to the health care of a covered injury and illness; an examination, evaluation, and opinion rendered by a health care specialist when requested by the authorized treating practitioner or by the employee; and which includes a history, examination, evaluation of treatment, and a written report. If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service(s) cease(s) to be a consultant service.
- (12) "CPT®" means the most current edition of the American Medical Association's Current Procedural Terminology.
- (13) "Critical care" has the same meaning as defined by Medicare.
- (14) "Day" means a calendar day, unless otherwise designated in these Rules.
- (15) "Diagnostic procedure" means a service which aids in determining the nature and/or cause of an occupational disease, illness or injury.
- (16) "Diagnostic Code" means the properly constructed numeric code from the International Classification of Diseases, version ICD-9-CM for dates of service before October 1, 2015. For dates of service on or after October 1, 2015, it means the properly constructed alpha-numeric code, ICD-10-CM.
- (17) "Dispute" means a disagreement between an employer and a health care provider on interpretation, payment under, or application of these Rules.
- (18) "MS-DRG" (Diagnosis Related Group) means one of the classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns as defined for Medicare.
- (19) "Durable Medical Equipment" or "DME" is equipment which:

(Rule 0800-02-17-.03, continued)

- (a) Can withstand repeated use;
 - (b) Is primarily and customarily used to serve a medical purpose;
 - (c) Generally is not useful to a person in the absence of illness, injury or occupational disease; and
 - (d) Is appropriate for use in the home.
- (20) "Employer" shall have the same meaning as defined in T.C.A. § 50-6-102, but also includes an employer's insurer, third party administrator, self-insured employers, self-insured pools and trusts, as well as the employer's legally authorized representative or legal counsel, and agents to accomplish billing and payment transactions, as applicable.
- (21) "Established patient" has the same meaning as in the most current version of the CPT®.
- (22) "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis.
- (23) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
- (24) "Follow-up care" means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum allowable payment, as defined by Medicare but does not include care for complications.
- (25) "Follow-up days" means the days of care following a surgical procedure that are included in the procedure's maximum allowable payment, as defined by Medicare but does not include care for complications.
- (26) "Follow-up visits" means the number of office visits following a surgical procedure which is included in the procedure's maximum allowable payment, as defined by Medicare but does not include care for complications.
- (27) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes, but is not limited to, a freestanding surgical outpatient facility, health maintenance organization, an industrial or other clinic, an occupational health care center, a home health agency, a visiting nurse association, a laboratory, a medical supply company, or a community mental health center.
- (28) "Health care review" means the review of a health care case or bill, or both, by an employer.
- (29) "Health Care Specialist" means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.
- (30) "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place as determined by the Administrator or the Administrator's designee after consultation with the Bureau's Medical Director.
- (31) "Incidental surgery" means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the original or covered diagnosis that is in accord with the Medicare rules.
- (32) "Independent Medical Examination" means an examination and evaluation conducted by a practitioner who has not previously been involved in providing care to the examinee. There is

(Rule 0800-02-17-.03, continued)

no doctor/therapist-patient relationship. This does not include one conducted under the Bureau's Medical Impairment Rating Registry ("MIRR") Program.

- (33) "Independent procedure" means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it according to CPT® guidelines.
- (34) "Injury" has the same meaning defined in T.C.A. § 50-6-102.
- (35) "Inpatient services" mean services rendered to a person who is formally admitted to a hospital and whose condition is such that requires Inpatient admission in accordance with industry standard guidelines.
- (36) "Institutional services" mean all non-physician services rendered within the institution by an agent of the institution.
- (37) "Maximum allowable payment" means the maximum fee for a procedure established by these Rules or the usual and customary bill as defined in these Rules, whichever is less, except as otherwise might be specified. In no event shall reimbursement be in excess of the Bureau's Medical Fee Schedule, unless otherwise authorized by the administrator. Fee collected in excess of the Bureau's Medical Fee Schedule and reported to the Bureau, may, at the Administrator's discretion, result in civil penalties of fifty dollars (\$50.00) to five thousand dollars (\$5,000.00) per violation for each violation assessed severally against the provider accepting such fee and the employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the Administrator's discretion, multiple violations by a provider may subject the provider to exclusion from participating in providing workers care under the Act.
- (38) "Maximum fee" means the maximum allowable payment for a procedure established by this rule, the Medical Fee Schedule and the In-patient Hospital Fee Schedule.
- (39) "Medical admission" means any hospital admission where the primary services rendered are not surgical or in an acute care hospital where the admission is to special unit such as inpatient psychiatric or rehab beds, or in a separately licensed psychiatric or rehabilitation hospital.
- (40) "Medical Director" means the Bureau's Medical Director appointed by the Administrator pursuant to T.C.A. § 50-6-126.
- (41) "Medical only case" means a case which does not involve lost work time.
- (42) "Medical supply" means either a piece of durable medical equipment or an expendable medical supply.
- (43) "Modifier code" means a 2-digit number or alphabetical designation used in conjunction with the procedure code to describe circumstances, as defined by CMS which arise in the treatment of an injured or ill employee.
- (44) "New patient" designation for billing purposes means a patient who is new to the provider according to the definitions in the most recent edition of CPT®.
- (45) "Operative report" means the practitioner's written description of the surgery and includes all of the following:
 - (a) A preoperative diagnosis;
 - (b) A postoperative diagnosis;

(Rule 0800-02-17-.03, continued)

- (c) A step-by-step description of the surgery;
 - (d) An identification of problems which occurred during surgery;
 - (e) The condition of the patient, when leaving the operating room, the practitioner's office, or the health care organization.
- (46) "Ophthalmologist" shall be defined according to T.C.A. § 71-4-102(3).
- (47) "Optician" shall mean a licensed dispensing optician as set forth in T.C.A. § 63-14-103.
- (48) "Optometrist" means an individual licensed to practice optometry.
- (49) "Optometry" shall be defined according to T.C.A. § 63-8-102(12).
- (50) "Orthotic equipment" means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.
- (51) "Orthotist" means a person skilled in the construction and application of orthotic equipment.
- (52) "Outpatient service" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities also known as ambulatory surgical centers.
- (53) "Package" means a surgical procedure that includes but is not limited to all of the following components:
- (a) The operation itself;
 - (b) Local infiltration;
 - (c) Topical anesthesia when used;
 - (d) The normal or global follow-up period and/or visits as defined by CPT®.
- (54) "Pattern of practice" means repeated, similar violations over a three-year period of the Medical Fee Schedule Rules.
- (55) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced and governed by the Board of Pharmacy.
- (56) "Practitioner" means a person licensed, registered, or certified as an audiologist, chiropractic physician, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional, or their agents used to accomplish medical records, billing and payment transactions.
- (57) "Preauthorization" for workers' compensation claims means that the employer prospectively, retrospectively, or concurrently authorizes the payment of medical benefits. Preauthorization for workers' compensation claims does not mean that the employer accepts the claim or has

(Rule 0800-02-17-.03, continued)

made a final determination on the compensability of the claim. Preauthorization for workers' compensation claims does not include utilization review.

- (58) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.
- (59) "Procedure" means a unit of health service.
- (60) "Procedure code" means an alpha/numeric or numeric sequence used to identify a service performed and billed by a qualified provider.
- (61) "Properly submitted and complete bill" means a request for a provider for payment of health care services submitted to the employer on the appropriate forms which are completed pursuant to this rule or the rules appropriate to electronic billing. To be properly submitted and complete, the bill shall:
- (a) Identify:
 - 1. The injured employee who received the service;
 - 2. The employer and the responsible paying agent with information sufficient to contact the responsible party in case of a dispute or questions. This information shall be provided by the payer if the bill is adjusted, contested or rejected and shall include a clear explanation of the reasons;
 - 3. The health care provider with an IRS, NPI or other appropriate identifier;
 - 4. The medical service product;
 - 5. Other information required by the form;
 - (b) Include a valid MS-DRG, Revenue Code, CPT® or HCPCS code as applicable;
 - (c) Include a ICD-10-CM codes where necessary shall be used by all parties;
 - (d) Have attached, in legible text, all supporting documentation required for the particular bill format, including, but not limited to, medical reports and records, evaluation reports, narrative reports, assessment reports, progress reports/notes, clinical notes, hospital records and diagnostic test results that may be expressly required by law or can reasonably be expected by the payer or its agent under the laws of Tennessee.
- (62) "Prosthesis" means an artificial substitute for a missing body part.
- (63) "Prosthetist" means a person skilled in the construction and application of prosthesis.
- (64) "Provider" means a facility, health care organization, or a practitioner, or their agents to accomplish medical records, correspondences, billing and payment transactions.
- (65) "Reject" means that an employer denies partial or total payment to a provider or denies a provider's request for reconsideration. Notification of any full or partial rejection must be made within fifteen (15) business days of receipt of the bill by the employer.
- (66) "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition, as defined by Medicare.

(Rule 0800-02-17-.03, continued)

- (67) "Stop-Loss Payment" or "SLP" means an independent method of payment for an unusually costly or lengthy stay.
- (68) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the Administrator to be used as a multiplier to establish a reimbursement amount when total hospital bills have exceeded specific stop-loss dollar thresholds.
- (69) "Stop-Loss Threshold" or "SLT" means a dollar threshold of bills established by the Administrator, beyond which reimbursement is calculated by multiplying the applicable SLRF times the total dollars billed following that particular dollar threshold.
- (70) "Surgical admission" means any hospital admission for which the patient has a surgical MS-DRG as defined by CMS.
- (71) "Timely Filing of bills for medical services" means the period of time within which a request for payment from a provider must be billed consistent with Medicare guideline time limits.
- (72) "Timely Payment" means the period of time that the employer has to remit payment to the provider.
- (73) "Transfer between facilities" means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. The transfer may or may not involve a change in the admittance status of the patient, i.e., patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in the facility in which the patient has been admitted. The transfer between facilities shall include costs related to transportation of patient to obtain medical care.
- (74) "Usual and customary" means eighty percent (80%) of a specific provider's billed charges.
- (75) "CMS-1500 or CMS-1450, UB04" or their successors means the most recent industry standard health insurance claim forms maintained for use by medical care providers and institutions, including the ADA form for dentists and the NCPDP WC/PC UCF for pharmacies.
- (76) "Utilization Review" means evaluation of the necessity, appropriateness, efficiency and quality of medical services, including the prescribing of one (1) or more Schedule II, III or IV controlled substances for pain management for a period of time exceeding ninety (90) days from the initial prescription of such controlled substances, provided to an injured or disabled employee based upon medically accepted standards and an objective evaluation of the medical care services provided; provided, that "utilization review" does not include the establishment of approved payment levels, a review of medical charges or fees, or an initial evaluation of an injured or disabled employee by a physician specializing in pain management. "Utilization review," also known as "Utilization management," does not include the evaluation or determination of causation or the compensability of a claim. For workers' compensation claims, "utilization review" is not a component of preauthorization. The employer shall be responsible for all costs associated with utilization review and shall in no event obligate the employee, health care provider or Bureau to pay for such services.

Authority: T.C.A. §§ 50-6-102, 50-6-202, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.04 RESERVED.

Authority: T.C.A. §§ 50-6-102 and 50-6-204 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.05 PROCEDURE CODES, ADOPTION OF THE CMS MEDICARE PROCEDURES, GUIDELINES AND AMOUNTS.

- (1) Services and medical supplies must be coded with valid procedure or supply codes of the Health Care Financing Administration Common Procedure Coding System (“HCPCS”). Procedure codes used in these rules were developed and copyrighted by the American Medical Association (“AMA”).
- (2) The most current effective editions of the American Medical Association’s Current Procedural Terminology (“CPT®”), the Medicare MS-DRG table and the Medicare RBRVS in effect on the date of service or date of discharge, and the National Correct Coding Initiative edits (“NCCI”) are incorporated in these Rules and must be used in conjunction with these Rules.
- (3) Unless otherwise explicitly stated in these Rules, the most current effective Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and are effective upon adoption and implementation by Medicare.
- (4) Whenever there is no specific fee or methodology for reimbursement set forth in these Rules, then the maximum amount of reimbursement shall be at 100% of the current, effective Medicare allowable amount. The effective Medicare guidelines and procedures on the date of service shall be followed in arriving at the correct amount, subject to the requirements of Rule 0800-02-18-.02(4). The Medical Fee Schedule conversion factor and TN specific conversion percentages may be, upon review by the Administrator, adjusted periodically. Whenever there is no applicable Medicare code or methodology, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in Rule 0800-02-17-.03 of this Chapter.
- (5) Telehealth: the definitions, licensing and processes for the purpose of these rules shall be the same as adopted by the Tennessee Department of Health. Payments shall be based upon the applicable Medicare guidelines and coding for the different service providers with the exception of any geographic restriction.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.06 PROCEDURES FOR WHICH CODES ARE NOT LISTED.

- (1) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale (“RBRVS”), the health care provider must use an appropriate CPT® procedure code or revenue code, as applicable. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the bill).

(Rule 0800-02-17-.06, continued)

- (2) The CPT® contains procedure codes for unlisted procedures. These codes should only be used when there is no procedure code which accurately describes the service rendered. A special report is required. These services are reimbursed BR (by report, see 0800-02-17-.03(6)).

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.07 MODIFIER CODES.

- (1) Modifiers listed in the most current CPT® shall be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.
- (2) The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of reasonableness and necessity and must be determined on a case-by-case basis.
- (3) When Modifier 21, 22, or 25 is used, a report explaining the medical necessity of the situation must be submitted to the employer. It is not appropriate to use Modifier 21, 22, or 25 for routine billing.
- (4) The maximum allowable additional amount under these Rules for Modifier 22 is 50%, not to exceed billed charges of the primary procedure.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.08 TOTAL PROCEDURES BILLED SEPARATELY.

- (1) Certain diagnostic procedures (neurological testing, radiology and pathology procedures, etc.) may be performed by two separate entities that also bill separately for the professional and technical components. When this occurs, the total reimbursement must not exceed the maximum medical fee schedule allowable for the procedure code listed.
 - (a) When billing for the professional component only, Modifier 26 must be added to the appropriate procedure code.
 - (b) When billing for the technical component only, Modifier TC (Technical Component) is to be added to the appropriate procedure code.

Authority: T.C.A. §§ 50-6-128, 50-6-204, and 50-6-205 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.09 INDEPENDENT MEDICAL EXAMINATION TO EVALUATE MEDICAL ASPECTS OF A CASE.

- (1) An Independent Medical Examination, other than one conducted under the Bureau's MIRR Program, shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. This service may be necessary in order to make a judgment regarding the current status of the injured or ill worker, or to determine the need for further health care.
- (2) An Independent Medical Examination, performed to evaluate the medical aspects of a case (other than one conducted under the Bureau's MIRR Program), shall be billed using the appropriate independent medical examination procedure, and shall include the practitioner's time only. Time spent shall include face-to-face time with the patient, time spent reviewing records, reports and studies, and time spent preparing reports. The office visit bill is included with the CPT® code, 99456, and shall not be billed separately. The total amount for an IME under this Rule shall not exceed \$500.00 per hour, and shall be pro-rated per half hour, i.e. two and one-half hours may not exceed \$1,250.00. Physicians may only require pre-payment of \$500.00 for an IME provided that following the completion of the IME and report, the physician may bill for other amounts appropriately due. The payer may recover any amounts that were overpaid.
- (3) Any laboratory procedure, x-ray procedure, and any other test which is needed to establish the worker's ability to return to work shall be identified by the appropriate procedure code established by this Rule and reimbursed accordingly.
- (4) Physicians who perform consultant services and/or records review in order to determine whether to accept a new patient shall not bill for an IME. Rather, such physicians shall bill using CPT codes 99358 and 99359. The reimbursement shall be \$200.00 for the first hour of review and \$100.00 for each additional hour, provided that each half hour shall be pro-rated. Any prepayment request may not exceed \$500.00.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.10 PAYMENT.

- (1) Reimbursement for all health care services and supplies shall be the lesser of (a) the provider's usual billed charge, (b) the maximum fee calculated according to these Rules (and/or any amendments to these Rules) or (c) the agreed contracted or published rate between the provider and the MCO/PPO pursuant to T.C.A. § 50-6-215. A licensed provider or institution shall receive no more than the maximum allowable payment, in accordance with these Rules, for appropriate health care services rendered to a person who is entitled to health care services under the Act. Any provider reimbursed or employer paying an amount which is in excess of these Rules shall have a period of one hundred eighty (180) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules.
- (2) The edition of the Medicare RBRVS: The Physicians' Guide in effect on the date of service or date of discharge is adopted by reference as part of these Rules. The Medicare RBRVS is distributed by the American Medical Association and by the Office of the Federal Register and is also available on the Internet at www.cms.hhs.gov/home/medicare.asp. Whenever a

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guideline or procedure is not set forth in these Rules, the Medicare guidelines and procedures in effect on the date of service shall be followed.

- (3) When extraordinary services resulting from severe head injuries, major burns, severe neurological injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to 150% of the professional service fees normally allowed under these Rules. Such cases shall be billed with modifier 21 or 22 (for CPT® coded procedures) and shall contain a detailed written description of the extraordinary service rendered and the need therefore. This provision does not apply to In-patient Hospital Care facility fees which are specifically addressed in the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19.
- (4) Billing for provider services shall be submitted on industry standard billing forms; UB-04, CMS-1450, CMS-1500, the ADA form for dental providers, and the NCPDP WC/PC UCF for pharmacies, or their official replacement forms. Electronic billing submissions shall be in accord with the Bureau's rules for electronic billing.
- (5) An employer's payment shall reflect any adjustments in the bill.
 - (a) An employer shall provide an explanation of medical benefits with current and complete contact information for to a health care provider whenever the employer's reimbursement differs from the amount billed by the provider, using industry standard remark codes.
 - (b) A provider shall not attempt to collect from the injured employee or employer any amounts properly reduced by the employer.
 - (c) All such communications shall comply with all applicable Medicare and HIPAA requirements.
 - (d) Remittances for electronically submitted bills shall be in accordance with the Bureau's rules for electronic billing.
- (6) All providers and carriers shall use electronic billing and EDI, if they have the capability to do so. All such communications shall comply with all applicable Medicare and HIPAA requirements.
- (7) An employer shall date stamp medical bills and reports not submitted electronically upon receipt. Payment for all properly submitted and complete bill not disputed within 15 business days (or uncontested portions of the bill) shall be made to the provider within thirty 30 calendar days.
- (8) The employer shall notify the provider within fifteen (15) business days of receipt of the bill that it was not properly submitted and specify the reason(s).
- (9) When an employer disputes a bill or portion thereof, the employer shall pay the undisputed portion of the bill within thirty (30) calendar days of receipt of a properly submitted bill.
- (10) Any provider not receiving timely payment of the undisputed portion of the provider's bill may institute a collection action in a state court having proper jurisdiction over such matters to obtain payment of the bill. Such providers, if they prevail, shall also be entitled to receive reasonable costs and attorney fees incurred in such collection actions to be paid by the employer.
- (11) Billings not submitted on the proper form, as prescribed in these Rules, the In-patient Hospital Fee Schedule Rules, and the Medical Fee Schedule Rules, may be returned to the provider

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for correction and resubmission. If an employer returns such billings, it must do so within 15 business days of receipt of the bill. The number of days between the date the employer returns the billing to the provider and the date the employer receives the corrected billing, shall not apply toward the thirty (30) calendar days within which the employer is required to make payment. The rules for electronic billing shall apply to the types of forms where applicable.

- (12) Payments to providers for initial examinations and treatment authorized by the carrier or employer shall be paid by that employer and shall not later be subject to reimbursement by the employee, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.
- (13) Provider requests for pre-payment may not exceed five hundred (\$500.00) dollars for any individual services except the impairment rating.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.11 REIMBURSEMENT FOR EMPLOYEE-PAID SERVICES.

Notwithstanding any other provision of this rule, if an employee has personally paid for a health care service and at a later date an employer is determined to be responsible for the payment for that specific service, then the employee shall be fully reimbursed by the employer. Medical Fee Schedule maximum payments may not apply under this provision. If the service delivered is determined to be reasonable and necessary, the reimbursed expenses may exceed the maximum fee schedule amount.

Authority: T.C.A. §§ 50-6-128, 50-6-204, and 50-6-205 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.12 RECOVERY OF PAYMENT.

Nothing in these Rules shall preclude the recovery of payment already made for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. Likewise, nothing in these Rules shall preclude any provider from receiving additional payment for services or supplies if it is properly due that provider and does not exceed the amount allowed by these Rules.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-226, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee stayed the amendment on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.13 PENALTIES FOR VIOLATIONS OF FEE SCHEDULE RULES.

- (1) Except when a waiver has been granted by the Bureau, providers shall not accept and employers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within these Rules, Medical

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Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer paying an amount in excess of these Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, shall be in violation of these Rules and may, at the Administrator's discretion, be subject to civil penalties of not less than fifty dollars (\$50.00) nor more than five thousand dollars (\$5,000.00) per violation, which may be assessed severally against the provider accepting such fee and the employer paying the excessive fee, except as authorized pursuant to T.C.A. § 50-6-204, whenever a pattern or practice of such activity is found. Any provider reimbursed or employer paying an amount which is in excess of these Rules shall have a period of one hundred eighty (180) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the these Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than fifty dollars (\$50.00) nor more five thousand dollars (\$5,000.00) per violation, at the discretion of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator.

- (2) A provider or employer found to be in violation of these Rules, may request a contested case hearing by requesting the hearing in writing within fifteen (15) business days of issuance of a Notice of Violation and, if applicable, notice of the assessment of civil penalties. If a request for hearing is not received by the Bureau within the fifteen (15) business days of issuance of the Notice of Violation, the determination of such violation shall be deemed a final order of the Bureau and not subject to further review. All rights, duties, obligations, and procedures applicable under the Bureau's Rules for Penalty Assessments and Hearing Contested Cases (Chapter 0800-02-13) are applicable under these Rules, including, but not limited to, the right to judicial review of any final Bureau decision.
- (3) A request for hearing shall be made to the Bureau in writing by an employer or provider notified of violation of these Rules.
- (4) Any request for a hearing shall be filed with the Bureau within fifteen (15) business days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) business days of the date of issuance of the Notice of Violation shall result in the decision of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator becoming a final order and not subject to further review.
- (5) The Administrator, Administrator's Designee, or an agency member appointed by the Administrator shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed. All procedural aspects set forth in the Bureau's Rules for Penalty Assessment and Hearing Contested Cases, Chapter 0800-02-13, shall apply and be followed in any such contested case hearing.
- (6) Upon receipt of a timely filed request for a hearing, the Administrator shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.14 MISSED APPOINTMENT.

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the Bureau, the case manager, or employer. If the case manager or employer fails to cancel the appointment not less than one (1) business day prior to the time of the appointment, the provider may bill the employer for the missed appointment using CPT® procedure code 99199, with a maximum fee being the amount which would have been allowed under these Rules had the patient not missed the appointment. The employer shall make payment to the provider for the missed appointment pursuant to these Rules. This amount shall not include any bill for diagnostic testing that would have been billed.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.15 MEDICAL REPORT OF INITIAL VISIT AND PROGRESS REPORTS FOR OTHER THAN IN-PATIENT HOSPITAL CARE.

- (1) Except for inpatient hospital care, a provider shall furnish the employer with a narrative medical report for the initial visit, all information pertinent to the compensable injury, illness, or occupational disease if requested within thirty (30) calendar days after examination or treatment of the injured employee.
- (2) If the provider continues to treat an injured or ill employee who is receiving temporary disability payments (total or partial) for the same compensable injury, illness or occupational disease, the provider shall provide an updated medical report to the employer, including an assessment of functional progress toward employment (restricted or unrestricted as appropriate), at intervals not to exceed sixty (60) calendar days.
- (3) The narrative medical report or the medical office visit note including an assessment of functional progress toward employment, of the initial visit and the progress or follow-up visit shall include (in addition to applicable identifying information) all of the following information:
 - (a) Subjective complaints and objective findings, including interpretation of diagnostic tests;
 - (b) For the narrative medical report of the initial visit, the history of the injury, and for the progress report(s), significant history since the last submission of a progress report and the diagnosis;
 - (c) As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment;
 - (d) Physical limitations and expected work restrictions and length of time of those limitations and/or restrictions if applicable.
- (4) When copies of narrative medical reports required by 0800-02-17-.15(1) and (2) are requested, the provider of the requested reports shall be reimbursed at the following rate: initial and subsequent reports - not to exceed \$10.00 for reports twenty (20) pages or less in length, and twenty-five (25) cents per page after the first twenty pages. Initial reports that are in addition to the standard medical office note shall be billed using procedure code WC101, subsequent reports shall be billed using procedure code WC102, and all final reports shall be billed using procedure code WC103. No charge is allowed for routine office notes as these are not considered narrative reports under this Rule. No fee shall be paid if a request for medical records does not produce any records.

(Rule 0800-02-17-.15, continued)

- (5) A medical provider shall complete any medical report required by the Bureau without charge except completion of the C-30A (Final Medical Report) or the C-32 (Standard Form Medical Report) or their replacement forms.
- (6) After an initial opinion on causation has been issued by the physician, a request for a subsequent review based upon new information not available to the physician initially, may be billed by the physician and paid by the requesting party under CPT® code 99358-9 (\$200/one hour or less and \$100 for an extra hour). No additional reimbursement is due for the initial opinion on causation or a response to a request for clarification (that does not include any new information) of a previously issued opinion on causation.
- (7) Extra time spent in explanation or discussion with an injured worker or the case manager (that is separate from the discussion with the injured worker) may be charged using CPT™ code 99354-52 up to a maximum payment of forty dollars (\$40), added to a standard E/M CPT® code if the extra service exceeds 15 minutes. Use code 99354 up to a maximum of eighty dollars (\$80) if that extra service exceeds 30 minutes. The Medicare allowable fee does not apply to the service. There is no extra reimbursement if the service is less than 15 minutes.
- (8) If a provider assesses, counsels or provides behavioral intervention to a Workers' Compensation patient for substance and/or alcohol use, or for substance and/or alcohol use disorder, the provider may charge for the extra time involved using CPT® code 99408 (or codes 96150-96155, if appropriate) up to a maximum of eighty dollars (\$80) in addition to a standard E/M code. An assessment by structured screening must be documented. The code may only be charged if the patient is on a long term (over 90 days) Schedule II medication or a combination of one or more Schedule II, III, and/or IV medications. The Medicare allowable fee does not apply to this service.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.16 ADDITIONAL RECORDS.

Nothing in this rule shall preclude an employer or an employee from requesting reports from a provider in addition to those specified in Rule 0800-02-17-.15.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.17 DEPOSITION/WITNESS APPEARANCES.

- (1) Any provider who gives a deposition or appears in person as a witness shall be allowed a fee. The fee for appearance in person as a witness should be negotiated and agreed to in advance.
- (2) Procedure Code 99075 must be used to bill for a deposition.
- (3) Licensed physicians shall be reimbursed for depositions at the rate established in Bureau's Rule Chapter 0800-02-16, and shall be subject to penalties under these Rules for charging any amount which exceeds that amount.

(Rule 0800-02-17-.17, continued)

- (4) Other providers giving depositions shall be reimbursed at a fee at or below the fee for a licensed physician agreed to in advance.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.18 OUT-OF-STATE PROVIDERS.

Upon waiver granted by the Bureau, providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers' Compensation Act may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided.

Authority: T.C.A. §§ 50-6-204 and 50-6-205. **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.19 PREAUTHORIZATION.

- (1) Preauthorization shall be required for all non-emergency hospitalizations, non-emergency transfers between facilities, and non-emergency surgery. Decisions regarding authorization shall be communicated to the requesting provider within seven (7) business days of the request being received. Failure to provide a timely decision within seven (7) business days shall result in the authorization being deemed approved.
- (2) If a provider makes a written request by fax or e-mail (and receives acknowledgement of receipt of the request) for authorization for a treatment at least 21 business days in advance of the anticipated date that treatment is to be delivered and has not been notified of a denial or modification in writing or confirmed telephone call or confirmed fax at least 7 business days in advance of the date of the proposed treatment, it is presumed to be medically necessary, a covered service, and to be paid for by the employer.
- (3) If a provider makes a verbal request for authorization, the burden of proof for showing that authorization was granted by the employer rests with the provider.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, and 50-6-205. **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.20 RESERVED.

Authority: T.C.A. §§ 50-6-102, 50-6-122, 50-6-124, 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed December 20, 2007; effective March 4, 2008. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.21 PROCESS FOR RESOLVING DISPUTES BETWEEN EMPLOYERS AND PROVIDERS REGARDING BILLS.

- (1) Disputes
 - (a) Unresolved disputes between an employer and provider concerning bills due to conflicting interpretation of these Rules and/or the Medical Fee Schedule Rules and/or the In-patient Hospital Fee Schedule Rules may be submitted to the Medical Payment Committee (the Committee) on or after July 1, 2014 in accordance with the provisions in T.C.A. § 50-6-125. A request for Committee Review may be submitted on the form posted by the Bureau within one (1) year of the date of service to: Medical Director of the Bureau of Workers' Compensation, Tennessee Department of Labor and Workforce Development, Suite 1-B, 220 French Landing Drive, Nashville, Tennessee 37243, or any subsequent address as prescribed by the Bureau.
 - (b) Valid requests for Committee Review must be accompanied by the form prescribed by the Bureau, must be legible and complete, and must contain copies of the following:
 1. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, bills for services rendered and any payment received, and an explanation of unusual services or circumstances;
 2. Copies of all explanations of benefit (EOB's);
 3. Supporting documentation and correspondence, if any;
 4. Specific information regarding the contacts made with the employer;
 5. A verified or declared written medical report signed by the provider and all pertinent medical records; and
 6. A redacted copy of the above information removing all patient specific identifying information.
 - (c) The party requesting Committee Review must send a copy of the request and all documentation accompanying the request to the opposing party at the same time it is submitted to the Medical Director.
 - (d) If the request for review does not contain proper documentation, then the Committee will decline to review the dispute. Likewise, if the timeframe in this Rule is not met, then the Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.
 - (e) Resubmission of a request will be entertained by the Bureau and the Medical Payment committee for 3 months from the date the Committee declined to hear the original dispute but only if pertinent or new information is forwarded with the resubmission.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.22 COMMITTEE REVIEW OF FEE SCHEDULE DISPUTES/HEARINGS.

- (1) Medical Payment Committee (the Committee) Review Procedure:
 - (a) When a valid request for Committee Review is received by the Bureau's Medical Director, the parties will be notified at least 7 business days in advance when the Committee will consider the dispute. The Committee may consider the dispute at any meeting during which it has a quorum of the voting members. Members may participate by telephone or by video conferencing or by properly executed proxy. Members that participate by telephone or video conferencing or properly executed proxy shall be counted as present for purposes of establishing a quorum.
 - (b) The parties will have the opportunity to submit documentary evidence and present arguments to the Committee prior to and during the Committee meeting in which the dispute will be heard.
 - (c) The Committee shall consider the dispute and issue its decision on the merits as to the proper resolution of the dispute, based upon a simple majority vote of the members present for the purpose of a quorum. If the dispute cannot be decided in one meeting, then the Committee may continue it to the next meeting.
 - (d) If the parties to the dispute do not follow the decision of the Committee, then either party may proceed in any court of law with proper jurisdiction to decide the dispute.
- (2) Computation of Time Periods:

In computing a period of time prescribed or allowed by the Rules, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day on which compliance therewith is required shall be included. If the last day within which an act shall be performed or an appeal filed is a Saturday, Sunday, or a legal holiday, the day shall be excluded, and the period shall run until the end of the next day which is not a Saturday, Sunday, or legal holiday. "Legal holiday" means those days designated as a Tennessee State holiday.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013).
Administrative History: Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.23 RESERVED.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233, and Public Chapters 282 & 289 (2013). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.24 PROVIDER AND FACILITY FEES FOR COPIES OF MEDICAL RECORDS.

- (1) Health care providers and facilities are entitled to recover an amount in accordance with Tenn. Code Ann. § 50-6-204 to cover the cost of copying documents requested by the employer, employee, attorneys, etc. Documentation which is submitted by the provider and/or facility, but was not specifically requested by the employer, shall not be allowed a copy charge. The cost set forth in this subsection shall also apply to paper records transmitted on a

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- disc or by other electronic means based upon the number of pages reproduced on the disc or other media.
- (2) Health care providers and facilities shall furnish an injured employee or the employee's attorney and employer or their legal representatives copies of records and reports as set forth in Tenn. Code Ann. § 50-6-204, as amended.
 - (3) Health care providers and facilities shall be reimbursed up to the usual and customary amount, as defined in these Rules at 0800-02-.03, for copying x-rays, microfilm or other non-paper records.
 - (4) The copying charge shall be paid by the party who requests the records.
 - (5) An itemized invoice shall accompany the copy. Payment of all charges shall be made within thirty (30) calendar days.
 - (6) There shall be no fee paid should a requested search not produce identified records.

Authority: T.C.A. §§ 50-6-204, 50-6-205, and 50-6-233 (Repl. 2005). **Administrative History:** Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Repeal and new rules filed November 27, 2017; effective February 25, 2018.

0800-02-17-.25 IMPAIRMENT RATINGS-EVALUATIONS AND IN MEDICAL RECORDS.

- (1) This rule applies to authorized treating physicians. This rule is not applicable to Independent Medical Examinations ("IME") or impairment ratings rendered as a part of an IME pursuant to Rule 0800-02-17-.09. As used in this Rule 0800-02-17-.25 only, an authorized treating physician is that physician, chiropractor or medical practitioner who determines the employee has reached maximum medical improvement regarding the condition or injury for which the physician has provided treatment. The authorized treating physician may include any of the following:
 - (a) A physician chosen from the panel required by T.C.A. § 50-6-204;
 - (b) A physician referred to by the physician chosen from the panel required by T.C.A. § 50-6-204;
 - (c) A physician recognized and authorized by the employer to treat an injured employee for a work-related injury; or
 - (d) A physician designated by the Bureau to treat an injured employee for a work-related injury.
- (2) The authorized treating physician is required and responsible for determining the employee's maximum medical improvement date (MMI) and providing the employee's impairment rating for the injury the physician is treating. In some circumstances, a work-related accident may lead to multiple injuries that require multiple authorized treating physicians. In such cases, the physician that is treating a distinct injury shall determine that the employee has reached maximum medical improvement as to that injury only and is required and responsible for providing an impairment rating for that injury only. An authorized treating physician shall not be required or responsible for providing an impairment rating for an injury that the physician is not treating. The authorized treating physician shall only be required to provide an impairment rating when the physician believes in good faith that the employee retains a permanent

(Rule 0800-02-17-.25, continued)

impairment upon reaching maximum medical improvement. If, after completion of the rating, it is determined that the employee has an impairment rating of zero, then the provisions of Rule 0800-02-17-.25(6) shall still apply. If the treating physician does not have a good faith belief that the employee retains a permanent impairment upon reaching maximum medical improvement, then the authorized treating physician shall still be required to complete an impairment rating on the Bureau's form but shall not charge a fee for the impairment rating.

- (3) All impairment ratings shall be made pursuant to T.C.A. § 50-6-204.
- (4) Within twenty-one (21) calendar days of the date the authorized treating physician determines the employee has reached maximum medical improvement, the authorized treating physician shall submit to the employer a fully completed report on a form prescribed by the Administrator. The employer shall submit a fully completed form to the Bureau (if requested) and the parties within thirty (30) calendar days of the date the authorized treating physician determines the employee has reached maximum medical improvement.
- (5) Upon determination of the employee's impairment rating, the authorized treating physician shall enter the employee's impairment rating into the employee's medical records. In a response to a request for medical records pursuant to T.C.A. § 50-6-204, a provider, authorized treating physician or hospital shall include the portion of the medical records that includes the impairment rating.
- (6) The authorized treating physician is required and responsible for providing the impairment rating, fully completing the report on a form prescribed by the Administrator, and submitting the report to the employer, as required by these Rules, using CPT® code 99455. Notwithstanding Rule 0800-02-17-.15, the authorized treating physician shall receive payment of no more than \$250.00 for these services to be paid by the employer. The payment shall only be made to the authorized treating physician, if the authorized treating physician documents the consultation with the applicable AMA Guides™. The authorized treating physician shall not require prepayment of such fee.
- (7) Failure to fully complete the form and submit it within the appropriate timeframes shall subject the employer or authorized treating physician, as applicable, to a civil penalty of \$100 for every fifteen (15) calendar days past the required date until the fully completed form is received by the parties and the Bureau (if requested).

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233, 50-6-246, and Public Chapters 282 & 289 (2013). **Administrative History:** Original rule filed December 20, 2007; effective March 4, 2008. Public necessity rule filed January 8, 2009; effective through June 22, 2009. Public necessity rule filed May 19, 2009; effective through October 31, 2009. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014. Repeal and new rules filed November 27, 2017; effective February 25, 2018.