

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

**CHAPTER 0800-02-18
MEDICAL FEE SCHEDULE**

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0800-02-18-.01 MEDICARE-BASIS FOR SYSTEM, APPLICABILITY, EFFECTIVE DATE AND CODING REFERENCES.

- (1) The Medical Fee Schedule of the Tennessee Bureau of Workers' Compensation (Bureau) is a Medicare-based system, but with multiple medical specialty Tennessee Specific conversion percentages. These Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Act. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' relative value units ("RVUs") which must be adjusted for the Tennessee Geographic Practice Index ("GPCI") and the Tennessee conversion percentages adopted by the Tennessee Bureau of Workers' Compensation in these Rules. These Medical Fee Schedule Rules must be used in conjunction with the current American Medical Association's (AMA) CPT® Code Guide, CMS Common Procedure Coding System ("HCPCS"), the current and effective Resource Based Relative Value Scale (RBRVS), as developed by the AMA and CMS, the American Society of Anesthesiologists (ASA) Relative Value Guide, the National Correct Coding Initiative edits (NCCI) and current effective Medicare procedures and guidelines, unless specifically exempted in these rules. 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, upon waiver granted by the Bureau.
- (2) These Medical Fee Schedule Rules must also be used in conjunction with Rules for Medical Payments, Chapter 0800-02-17, and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19. The definitions set out in those rules, as well as the other general provisions, including but not limited to those regarding electronic billing and prompt payment of provider's bills, are adopted by reference as if set forth fully herein.
- (3) These Medical Fee Schedule Rules apply to all services provided after the effective date of these rules. The most recent versions of the American Medical Association's CPT® and the Medicare RBRVS shall automatically be applicable and are adopted by these Rules by reference upon their effective dates. Fees shall be calculated using the edition of the CPT® and RBRVS effective on the date of service, including rules concerning "families" of procedures, add-on codes, status indicators, and multiple procedure discounts in all places of service, except where exceptions are specified in these rules.

(Rule 0800-02-18, -.01, continued)

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 December 20, 2007; effective March 4, 2008. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.02 GENERAL INFORMATION AND INSTRUCTIONS FOR USE.

(1) Format

- (a) These Rules address and consist of the following sections: General Guidelines, General Medicine (including Evaluation and Management), General Surgery, Neuro- and Orthopedic Surgery, Radiology, Pathology, Anesthesiology, Injections, Durable Medical Equipment, Implants and Orthotics, Pharmacy, Physical and Occupational Therapy, Ambulatory Surgical Centers and Outpatient Hospital Care, Chiropractic, Ambulance Services and Clinical Psychological Services. Providers should consult and use the section(s) containing the procedure(s) they perform, or the service(s) they render, together with the appropriate sections of the Rules for Medical Payments, and the In-patient Hospital Fee Schedule Rules, if applicable, and the NCPDP WC/PC UCF for pharmacies.

(2) Reimbursement

- (a) Unless otherwise indicated herein, the most recent, effective Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the Medicare allowable amount, in effect on the date of service. The Medicare guidelines and procedures, in effect at the date of service, shall be followed in arriving at the correct amount. For purposes of these Rules, the base Medicare amount may be adjusted at the discretion of the Administrator based upon the Medicare Economic Index adjustment. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in the Rules for Medical Payments.
- (b) Reimbursement to all providers shall be the lesser of the following:
1. The provider's usual charge;
 2. The fee calculated according to the Medical Fee Schedule Rules (includes 100% of Medicare if no other specific fee or methodology is set forth in these Rules);
 3. The MCO/PPO or any other contracted price;
 4. Except when a waiver is granted by the Bureau, in no event shall reimbursement be in excess of these Fee Schedule Rules that are in force on the date of service unless otherwise provided in T.C.A § 50-6-204 or in the Bureau's rules. Reimbursement in excess of the Medical Fee Schedule Rules may result in civil penalties, at the Administrator's discretion, of from \$50.00 (fifty dollars) up to \$5,000.00 (five thousand dollars) per violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, should a pattern or practice of such activity be found. It is recognized that providers must bill all payers at the same amount and simply billing an amount

(Rule 0800-02-18, -.02, continued)

which exceeds the Fee Schedule Rules does not constitute a violation. It is acceptance and retention of an amount in excess of this Fee Schedule Rules for longer than one hundred eighty (180) calendar days that constitutes a violation by a provider. At the Administrator's discretion, multiple violations may subject the provider to exclusion from participating in the program of the Tennessee Workers' Compensation Act ("Act"). Any provider reimbursed or carrier paying an amount which is in excess of the maximum amount allowed under these Rules shall have a period of one hundred eighty (180) calendar days from the time of receipt or payment of such excessive payment in which to refund/recover the overpayment amount. If such amount is refunded or recovered within this one hundred eighty (180) calendar day time period, the overpayment shall not be considered a violation of these Rules by the provider or employer and shall not be the basis for a penalty against the provider receiving or employer paying the excessive payment.

5. The "lesser of" comparison among:
 - (i) The provider's usual charge;
 - (ii) The maximum allowable amount pursuant to these Rules; or
 - (iii) Any other contracted amount.
 - (iv) These comparisons shall be determined based on the entire bill or an amount due for a particular service, rather than on a line-by-line basis.

(3) Fee Schedule Calculations

The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT® code by multiplying the Medicare relative value units (RVU) with the Medicare Tennessee specific Geographic Practice Cost Index (GPCI) to establish the total Tennessee RVUs. That figure is then multiplied by the appropriate conversion factor to establish the base payment amount. This base payment amount is multiplied by the appropriate Medical Fee Schedule Tennessee specific conversion percentage. Whether one uses the facility or non-facility RVUs is determined using the effective Medicare guidelines on the date of service and is dependent upon the location at which the service is provided. Certain specialty areas listed below do not have a specific conversion factor and the maximum reimbursement amount allowed is the usual and customary amount defined in the Rules for Medical Payments, as indicated. For areas not listed, the maximum allowable amount is 100% of the Tennessee specific Medicare allowable amount calculated in accordance with Medicare guidelines and methodology effective on the date of service, except where a waiver has been granted by the bureau.

- (4) Practitioner fees shall be based on the Medical Fee Schedule conversion factor of 33.9764, which shall be used in conjunction with the effective Medicare RVUs on the date of service, as adjusted above. The Administrator may designate another Medical Fee Schedule conversion factor at any time. The Tennessee-Specific Conversion percentage listed below should be applied to the appropriate service category in order to calculate the correct charge or billing amount (Anesthesia by units, see Rule 0800-02-18-.05):

Service Category by Medical Specialty	TN Specific Conversion %
Anesthesiology.....	\$75.00 per unit
Orthopaedics and Neurosurgery*275%

(Rule 0800-02-18, -.02, continued)

General Surgery.....	200%
Radiology.....	200%
Pathology.....	200%
Physical/Occupational Therapy.....	130%
Chiropractic.....	130%
General Medicine (including Evaluation & Management).....	160%

All Evaluation and Management (E/M) codes are paid at 160% (not specialty dependent). This percentage is not applicable to PA and NP charges, who shall be paid at the standard Medicare rates. See 0800-02-18-.04(2)(c) for rates for surgery involving a PA or NP.

Emergency Care.....	200%
Home Health Services (episodic and not “LUPA” adjustment).....	100% of Medicare
Dentistry.....	100% using ADA dental codes.

Oral Surgery follows the surgery percentage when using CPT® codes.

* Board certified or Board eligible Orthopaedists and Neurosurgeons may use the modifier “ON” on the appropriate billing form when submitting surgical charges. If the modifier or another indicator is not placed on the form, then the Tennessee Department of Health’s database may be consulted in order to determine the provider’s specialty.

(5) Forms

- (a) The following forms (or their official replacements) should be used for provider billing: the effective current version of the CMS 1500 and UB 04 or the electronic equivalents.
- (b) Bills for reimbursement shall be sent directly to the employer responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Insurance Carriers and/or Employers shall furnish this billing information to the Providers, and such information must be accurate and updated, within thirty (30) calendar days of any change to the billing address of the responsible party, either mail, e-mail or electronic submission.

(6) Violations of Fee Schedule Rules and Rules for Medical Payments

The Administrator, Administrator’s Designee, or an agency member appointed by the Administrator, shall have the authority to issue civil penalties from \$50.00 (fifty dollars) up to \$5,000.00 (five thousand dollars) per violation for violations of the Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules or the Rules for Medical Payments (“Rules”) as prescribed in the Rules. Any party notified of an alleged violation shall be entitled to a contested case hearing before the Administrator, Administrator’s Designee, or an agency member appointed by the Administrator pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., if a written request is submitted to the Bureau by the party within fifteen (15) calendar days of issuance of notice of such violations and of any civil penalty. Failure to make a timely request will result in the violation and penalty decision becoming a final order and not subject to further review.

(Rule 0800-02-18, -.02, continued)

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. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. Amendments filed December 20, 2007; effective March 4, 2008. Amendments filed June 12, 2009; effective August 26, 2009. Emergency rule filed September 2, 2011; effective through February 29, 2012. Withdrawal of emergency rule 0800-02-18(4) filed November 8, 2011 by the Department of Labor and Workforce Development; withdrawal effective November 8, 2011. 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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.03 GENERAL GUIDELINES.

- (1) Guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in a particular section and provide explanations regarding terms that apply only to a particular section.
- (2) The Guidelines found in the editions of the AMA CPT® Guide and Medicare RBRVS in effect on the date of service The Physicians' Guide applies to the following: General Medicine (includes Evaluation and Management), General Surgery, Neuro-surgery, Orthopedic Surgery, Chiropractic, Physical and Occupational Therapy, Home Health Care, Home Infusion, Ambulatory Surgical Centers and Outpatient Hospital Services, Radiology, Clinical Psychological, and Pathology. Codes of dental terminology prescribed by the American Dental Association, including the terminology updates and revisions issued in the future by the American Dental Association shall be used for all Dentistry services.
- (3) In addition to the Guidelines found in the AMA CPT® and the Medicare RBRVS: The Physicians' Guide, the following Medical Fee Schedule Rule Guidelines also apply. For a Tennessee claim, whenever a conflict exists between these Medical Fee Schedule Rules and any other state fee schedule, rule or regulation, these Rules shall govern.
- (4) For free standing or in-office laboratory, pathology and toxicology procedures including urine drug screens (UDS), these services shall be reimbursed at the pathology percentage when there is a G code or applicable cross-walk CPT® code. For any urine drug screens, the laboratory requisition must specify exactly which drugs are to be tested and why. The billing code(s) submitted shall be those recognized by Medicare as appropriate for the date of service. The frequency of urine drug screens should be in accord with the most recent version of the Department of Health Tennessee Chronic Pain Guidelines, Clinical Practice Guidelines for the Outpatient Management of Chronic Non-Malignant Pain.

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 November 27, 2017; effective February 25, 2018.

0800-02-18-.04 SURGERY GUIDELINES.

- (1) Multiple Procedures: Maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus each additional appropriately coded secondary and/or multiple procedures according to Medicare guidelines (including endoscopy and other applicable "families) and CPT® CCI edits.
- (2) Services Rendered by More Than One Physician:

(Rule 0800-02-18-.04, continued)

- (a) Concurrent Care: One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.
 - (b) Surgical Assistant: A physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services provided by physicians, Modifier 80 or 81 shall be added to the surgical procedure code which is billed. A physician serving as a surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount.
 - (c) Appropriately licensed Physician Assistants and Advance Practice Nurses (Nurse Practitioners) may serve as surgical assistants as deemed appropriate by the physician, and if so, that assistants' reimbursement shall not exceed 100% of the Physician Assistant fee or Advance Practice Nurse fee that would be due under Medicare guidelines, without regard to conversion factors or percentages applicable to their supervising physician specialty contained in this Medical Fee Schedule.
 - (d) Two Surgeons: For reporting see the most current CPT®. Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the employer has received each surgeon's individual operative report and bill. Reimbursement to both surgeons shall be in accord with Medicare guidelines.
 - (e) The need for a surgical assistant, assisting surgeon, co-surgeon, second surgeon or team surgery will follow Medicare status indicators. The payment amount will depend on the specialty as designated in 0800-02-18-.02(4) and 0800-02-18-.04(2).
- (3) When a surgical fee is chargeable, no office visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination, in accord with Medicare guidelines. All exceptions require use of the appropriate modifiers.
 - (4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge, commonly known as a global fee. Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.05 ANESTHESIA GUIDELINES.

- (1) General Information and Instructions.
 - (a) The current ASA Relative Value Guide, by the American Society of Anesthesiologists will be used to determine reimbursement for anesthesia codes that do not appear in the RBRVS. These values are to be used only when the anesthesia is personally

(Rule 0800-02-18-.05, continued)

administered by an Anesthesiologist or Certified Registered Nurse Anesthetist (“CRNA”) who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service.

- (b) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, maximum reimbursement shall be 90% of the maximum allowable fee for anesthesiologists under these Medical Fee Schedule Rules. No additional payment will be made to any physician supervising the CRNA.
- (c) Whenever anesthesia services are provided by an anesthesiologist or other physician and a CRNA, reimbursement shall never exceed 100% of the maximum amount an anesthesiologist or physician would have been allowed under these Medical Fee Schedule Rules had the anesthesiologist or physician alone performed these services.

(2) Anesthesia Values

- (a) Each anesthesia service contains two value components which make up the charge and determine reimbursement: a Basic Value and a Time Value, and physical status modifiers and qualifying circumstance codes that may be appropriately added according to Medicare guidelines.
- (b) Basic Value: This relates to the complexity of the service and includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. The Basic Value includes usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood products incidental to the anesthesia or surgery and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during an operative session, the Basic Value for anesthesia is the Basic Value for the procedure with the highest unit value. The Basic Values in units for each anesthesia procedure code are listed in the current ASA Relative Value Guide.
- (c) Time Value: Anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for induction of anesthesia and ends when the personal attendance of the anesthesiologist or CRNA is no longer required and the patient can be safely placed under customary, postoperative supervision. Anesthesia time must be reported on the claim form as the total number of minutes of anesthesia. For example, one hour and eleven minutes equals 71 minutes of anesthesia. The Time Value is converted into units for reimbursement as follows:
 - 1. Each 15 minutes equals one (1) time unit.
 - 2. No additional time units are allowed for recovery room observation monitoring after the patient can be safely placed under customary post-operative supervision.

(3) Total Anesthesia Value

- (a) The total anesthesia value (“TAV”) for an anesthesia service is the sum of the Basic Value (units) plus the Time Value which has been converted into units, and physical status modifiers and qualifying circumstance codes that may be appropriately added according to Medicare guidelines. The TAV is calculated for the purpose of determining reimbursement.

(4) Billing

(Rule 0800-02-18-.05, continued)

- (a) Anesthesia services must be reported by entering the appropriate anesthesia procedure code and descriptor into Element 24 D of the HCFA 1500 Form. The provider's usual total charge for the anesthesia service must be entered in Element 24 F on the HCFA 1500 Form, or its presently accepted equivalent. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form. Include the appropriate modifiers.
- (5) Reimbursement
- (a) Reimbursement for anesthesia services shall not exceed the maximum allowable Medical Fee Schedule amount of \$75.00 per unit.
- (6) Medical Direction Provided by Anesthesiologists
- (a) When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and post-operative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post-anesthesia recovery areas, except in an appropriately documented emergency situation. Total reimbursement for the nurse anesthetist and the anesthesiologist shall not exceed the maximum amount allowable under the Medical Fee Schedule Rules had the anesthesiologist alone performed the services.
- (7) Anesthesia by Surgeon
- (a) Local Anesthesia
When infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgeon's assistant, reimbursement for the procedure and anesthesia are included in the global reimbursement for the procedure.
 - (b) Regional or General Anesthesia
When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, payment is included in the surgical procedure reimbursement, according to Medicare guidelines.
- (8) Unlisted Service, Procedure or Unit Value. When an unlisted service or procedure is provided or without specified unit values, the values used shall be substantiated by report.
- (9) Procedures Listed In The ASA Relative Value Guide Without Specified Unit Values. For any procedure or service that is unlisted or without specified unit value, the physician or anesthetist shall establish a unit value consistent in relativity with other unit values shown in the current ASA Relative Value Guide. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equipment necessary, etc., shall be furnished. Sufficient information shall be furnished to identify the problem and the service(s).
- (10) Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file.
- (11) Special Supplies. Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately. Drugs, materials provided, and tray supplies shall be listed separately. Supplies and materials provided in a hospital or other facility must not be billed separately by the physician or CRNA.

(Rule 0800-02-18-.05, continued)

- (12) Separate or Multiple Procedures. It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

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 December 20, 2007; effective March 4, 2008. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.06 INJECTIONS GUIDELINES.

Reimbursement for injection(s) (such as J codes) includes allowance for CPT® code 96372. Surgery procedure codes defined as injections include the administration portion of payment for the medications billed. J Codes are found in the Health Care Financing Administration Common Procedure Coding System (“HCPCS”). Follow the Medicare guidelines in effect for the date of service for both single and multiple use vials of injectable medications for both medications and procedures. Immunization codes (vaccines and toxoid) should be reimbursed for both the medication and the procedure, reported separately with number of units administered.

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 November 27, 2017; effective February 25, 2018.

0800-02-18-.07 AMBULATORY SURGICAL CENTERS AND OUTPATIENT HOSPITAL CARE (INCLUDING EMERGENCY ROOM FACILITY CHARGES).

- (1) Medically appropriate surgical procedures may be performed on an outpatient basis.
- (a) For the purpose of the Medical Fee Schedule Rules, “ambulatory surgical center” means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgical center may be a free standing facility or may be attached to a hospital facility. For purposes of workers’ compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.
- (b) The CMS has implemented the Outpatient Prospective Payment System (“OPPS”) under Medicare for reimbursement for hospital outpatient services at most hospitals. All services paid under the new OPPS are classified into groups called Ambulatory Payment Classifications (“APC”). Services in each APC are similar clinically and in terms of the resources they require. The CMS has established a payment rate for each APC. Current APC Medicare allowable payment amounts and guidelines are available online at: <http://www.cms.hhs.gov/HospitalOutpatientPPS>. The payment rate for each APC group is the basis for determining the maximum total payment to which an ASC or hospital outpatient center will be entitled, including add-ons, hospital outpatient procedures, multiple procedure discounts and status indicators, according to current CMS guidelines.
- (c) Under the Medical Fee Schedule Rules, the OPPS reimbursement system shall be used for reimbursement for all outpatient services, wherever they are performed, in a free-standing ASC or hospital setting. The most current, effective Medicare APC rates shall be used as the basis for facility fees charged for outpatient services and shall be reimbursed at a maximum of 150% of current value for such services. Depending on the services provided, ASCs and hospitals may be paid for more than one APC for an

(Rule 0800-02-18-.07, continued)

encounter. When multiple surgical procedures are performed during the same surgical session, Medicare guidelines shall be used in determining separate and distinct surgical procedures and the order of payment.

- (d) If a claim contains services that result in an APC payment but also contains packaged services, separate payment of the packaged services is not made since the payment is included in the APC. However, charges related to the packaged services are used in setting outlier calculations.
- (e) Reimbursement for all outpatient services is based on the Medicare Ambulatory Payment Classification ("APC") national unadjusted base rates, which can be obtained from the Centers for Medicare and Medicaid Services. There are no adjustments for wage-price indices and these are not hospital-specific APC rate calculations. Reimbursements for Critical Access Hospitals ("CAH") are not based on CAH methodology but on the national unadjusted APC base rates as described in the preceding sentence.
- (f) Status indicators used under Medicare should be interpreted using Medicare guidelines with the exception of status indicator "C," which Medicare does not reimburse for outpatient services, but requires inpatient treatment. Under these Rules, these procedures listed with status indicator "C" performed on an outpatient basis shall be reimbursed, but with the maximum amount being usual & customary, which is 80% of the billed charges, as defined in the Bureau's Rules for Medical Payments.
- (g) All other outpatient hospital care in all ASCs and all hospitals, including but not limited to observation and emergency room facility fees, shall be calculated in accordance with the most current Medicare rules and procedures applicable to such services and shall be reimbursed at a maximum rate of 150% of the current value of Medicare reimbursement for outpatient hospital care.
- (h) All of the following services are to be reimbursed in accordance with the Medicare status indicators effective on the date of service or according to the Medicare guidelines concerning hospital outpatient diagnostic services rates, in effect on the date of service.
 1. Physician services, including pathologists, radiologists and anesthesiologists and CRNAs.
 2. Radiology services (technical components may only be separately reimbursed when not included in APC)
 3. Diagnostic procedures not related to the surgical procedure
 4. Prosthetic devices
 5. Ambulance services
 6. Orthotics
 7. Implantables
 8. DME for use in the patient's home
 9. Take home medications
 10. Take home supplies

(Rule 0800-02-18-.07, continued)

- (i) 1. For cases involving implantation of medical devices (implantables), regardless of the current Medicare status indicators, payment shall be made only to the facility.
- 2. For DME, orthotics and prosthetics used in the patient's home that is supplied by the facility, payment shall be made only to the facility (at the rates specified in 0800-02-18-.10 and 0800-02-18-.11), and not to any other separate entity for these services. No extra payment shall be made for these services if according to CMS regulations and status indicators when those particular services are included in the APC payment.
- (j) The listed services and supplies in subsection (1)(h) above shall be reimbursed according to the Medical Fee Schedule Rules, or at the usual and customary amount, as defined in these Rules, for items/services not specifically addressed in the Medical Fee Schedule Rules.
- (k) Pre-admission lab and x-ray may be billed separately from the Ambulatory Surgery bill when performed 24 hours or more prior to admission, and will be reimbursed the lesser of billed charges or the payment limit of the fee schedule, according to Medicare guidelines. Pre-admission lab and radiology are not included in the facility fee.
- (l) Facility fees for surgical procedures not listed shall be reimbursed by report with a maximum of the usual and customary rate as defined in the Division's Rule 0800-02-17-.03.
- (m) There may be emergency cases or other occasions in which the patient was scheduled for outpatient surgery and it becomes necessary to admit the patient. All hospitals with ambulatory patients who stay longer than 23 hours past ambulatory surgery or other diagnostic procedures and are formally admitted to the hospital as an inpatient will be paid in accordance with the In-patient Hospital Fee Schedule Rules, 0800-02-19. Medicare hospital criteria shall apply to these cases.

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. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. Amendment filed December 20, 2007; effective March 4, 2008. 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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.08 CHIROPRACTIC SERVICES GUIDELINES.

- (1) Charges for chiropractic services shall not exceed 130% of the participating fees prescribed in the Medicare RBRVS System fee schedule. The number of approved visits shall be limited pursuant to any restrictions in Tenn. Code Ann. § 50-6-204. The same procedures for utilization review applicable to physical therapy and occupational therapy services under Rule 0800-02-18-.09(5) below apply to chiropractic services.
- (2) For chiropractic services, an office visit (E/M code) may only be billed on the same day as a manipulation when it is the patient's initial visit with that provider. During the course of treatment, the chiropractor may bill a second E/M code if the patient does not adequately respond to the initial treatment regimen, and a documented significant change is made in the treatment recommendations.

(Rule 0800-02-18, -.08, continued)

- (3) There shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee. The Medicare definition of modality is applicable.
- (4) There shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.
- (5) If the Bureau's adopted treatment guidelines allow for exceptions such as but not limited to the number of modalities or visits, then the guidelines may be used.

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. 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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.09 OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY GUIDELINES.

- (1) Reimbursement for all physical and occupational therapy services shall not exceed one hundred thirty percent (130%) of the maximum allowable fees prescribed in the Medicare RBRVS fee schedule, no matter where the services are performed, except home health services.
- (2) For physical therapy and/or occupational therapy, there shall be no reimbursement for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.
- (3) For physical therapy and/or occupational therapy, there shall be no fee allowable for any modalities or therapeutic procedures performed in excess of four (4) modalities, therapeutic procedures, or combination thereof per day per employee, with no additional reductions such as those to the relative value units (RVUs). The definitions of modality and therapeutic procedures from the most recent American Medical Association's Current Procedural Terminology (CPT®) edition are applicable.
- (4) For a Functional Capacity Evaluations, the four unit (time measurement) maximum may not apply as long as the documentation supports the extra units. The most recent CPT® codes available for Functional Capacity Evaluations are appropriate for use under the Tennessee Workers' Compensation Medical Fee Schedule.
- (5) Work Hardening/Conditioning Programs using the approved CPT® codes shall be billed at Usual and Customary hourly charges for a maximum of 6 hours per day or 60 hour maximum and are subject to utilization review prior approval. Payment is 80% of the billed charges.
- (6) Whenever physical therapy and/or occupational therapy services exceed twelve (12) visits, such treatment may be reviewed pursuant to the employer's utilization review program in accordance with the procedures set forth in Chapter 0800-02-06 of the Bureau's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the employer. Such certification shall be completed within the timeframes set forth in Chapter 0800-02-06 to assure no interruption in delivery of needed services. Failure by a provider to properly certify such services as prescribed herein may result in the forfeiture of any payment for uncertified services. Failure by an employer or utilization review organization to conduct utilization review in accordance with this Chapter 0800-02-18 and Chapter 0800-02-06 shall result in no more than twelve (12) additional visits being deemed certified. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of visits. If

(Rule 0800-02-18, -.09, continued)

necessary, further subsequent utilization review may be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate; provided, that further certifications are not required to be in increments of twelve (12) visits.

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. Emergency rules filed April 27, 2006; effective through October 9, 2006. Amendment filed January 8, 2007; effective March 24, 2007. 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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-10 DURABLE MEDICAL EQUIPMENT AND IMPLANTABLES.

- (1) Reimbursement for durable medical equipment and implantables for which billed charges:
 - (a) Are \$100.00 or less shall be limited to eighty (80%) of billed charges;
 - (b) Exceed \$100.00 shall be reimbursed at a maximum amount of the supplier or manufacturer's invoice amount, plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. These calculations are per item and are not cumulative. Charges for durable medical equipment and implantables are in addition to, and shall be billed separately from, all facility and professional service fees.
 - (c) This Rule shall not apply to durable medical equipment and medical supplies, other than implantables with applicable Medicare allowable amounts. Such durable medical equipment and medical supplies, including home DMEs, infusion and oxygen services, other than implantables, shall be reimbursed at the lesser of the billed charges or 100% of the applicable Medicare allowable amount.
- (2) Quality. The reimbursement for supplies/equipment in this fee guideline is based on a presumption that the injured worker is being provided the highest quality of supplies/equipment. All billing must contain the brand name, model number, and catalog number.
- (3) Rental/Purchase. Rental fees are applicable in instances of short-term utilization (30-60 days). The maximum allowable rental fee for DME is 100% of the Tennessee Medicare allowable amount. If it is more cost effective to purchase an item rather than rent it, this must be stressed and brought to the attention of the insurance carrier. The first month's rent should apply to the purchase price. However, if the decision to purchase an item is delayed by the insurance carrier, subsequent rental fees cannot be applied to the purchase price. When billing for rental, identify with modifier "RR".
- (4) TENs Units. All bills submitted to the carrier for Tens and Cranial Electrical Stimulator (CES) units should be accompanied by a copy of the invoice, if available.
 - (a) Rentals
 1. Include the following supplies:
 - (i) Lead wires;
 - (ii) Two (2) rechargeable batteries;
 - (iii) Battery charger;

(Rule 0800-02-18-.10, continued)

- (iv) Electrodes; and
 - (v) Instruction manual and/or audio tape.
 - 2. Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and "BR."
 - 3. Limited to 30 days trial period.
 - (b) Purchase:
 - 1. Prior to the completion of the 30-day trial period, the prescribing doctor must submit a report documenting the medical justification for the continued use of the unit. The report should identify the following:
 - (i) Describe the condition and diagnosis that necessitates the use of a TENS unit.
 - (ii) Does the patient have any other implants which would affect the performance of the TENS unit or the implanted unit?
 - (iii) Was the TENS unit effective for pain control during the trial period?
 - (iv) Was the patient instructed on the proper use of the TENS unit during the trial period?
 - (v) How often does the patient use the TENS unit?
 - 2. The purchase price should include the items below if not already included with the rental:
 - (i) Lead wires;
 - (ii) Two (2) rechargeable batteries; and
 - (iii) Battery charger.
 - 3. Only the first month's rental price shall be credited to purchase price.
 - 4. The provider shall indicate TENS manufacturer, model name, and serial number.
- (5) Continuous Passive Motion and Other External Exercise/Treatment Devices (see Medicare Code)
 - (a) Use of this unit in excess of the days recommended by the Bureau's adopted treatment guidelines requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.
 - (b) The use of cold compression therapy units and other external exercise/treatment devices in excess of 7 days (or the length of use recommended by the Bureau's adopted treatment guidelines) requires documentation of the device's use and medical necessity and may be subject to utilization review.

(Rule 0800-02-18-.10, continued)

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 December 20, 2007; effective March 4, 2008. Amendments 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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.11 ORTHOTICS AND PROSTHETICS GUIDELINES.

- (1) Orthotics and prosthetics, not supplied under 0800-02-18-.07, should be coded according to the HCFA Common Procedures Coding System (HCPCS). Payment shall be 115% of Tennessee Medicare allowable amount. If the invoice costs exceed the Medicare payments amounts at the time of delivery, the payment for orthotics and prosthetics shall be the higher of invoice costs or 115% of the Tennessee Medicare allowable amount and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from all other facility and professional service fees. Supplies and equipment should be coded 99070 if appropriate codes are not available in the HCPCS and the maximum reimbursement shall be the usual and customary amount. Charges should be submitted on the HCFA 1500 form or its approved successor form.
- (2) Fitting and customizing codes may be reimbursed separately according to Medicare guidelines.

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 December 20, 2007; effective March 4, 2008. Amendment filed June 12, 2009; effective August 26, 2009. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.12 PHARMACEUTICAL SCHEDULE GUIDELINES.

- (1) The Pharmacy Fee Guideline maximum allowable amount for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Tennessee workers' compensation laws is the lesser of:
 - (a) The provider's usual charge;
 - (b) A negotiated contract or lower amount; or
 - (c) The fees established by the formula for brand-name and generic pharmaceuticals as described in the following subsections.
 - (d) Prescribed Medication Services
 1. "Drug" has the meaning set out in Tenn. Code Ann. § 63-10-204.
 2. Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.
 3. Carriers may contract with pharmacy benefit managers to process and administer claims for reimbursement of pharmacy services and review the relatedness and appropriateness of prescribed services. Carriers and pharmacists may also negotiate alternative reimbursement schedules and amounts, so long as the reimbursement amount does not exceed the fee schedule amount set out in these Rules.

(Rule 0800-02-18-.12, continued)

4. For the purposes of these Medical Fee Schedule Rules, medicines are defined as drugs prescribed by an authorized health care provider and include only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription “dispense as written.”

(e) Reimbursement

1. The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists) is the lesser of:
 - (i) Average Wholesale Price* (“AWP”) + \$5.10 filling fee; (only the original manufacturer’s NDC number should be used in determining AWP); or
 - (ii) A negotiated contractual amount, that is less than or equal to the above reimbursements.
2. If the original manufacturer’s NDC number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis.
3. Reimbursement to pharmacists or any third-party billing agency or other contracted agent of a pharmacy shall never exceed the maximum amount calculated by the pharmaceutical reimbursement formula for prescribed drugs. The usual and customary charge of the pharmacy for the medication must be included on each bill. A generic drug must be substituted for any brand name drug unless there is no pharmaceutical and bioequivalent drug available, or the prescribing physician indicates that substitutions are prohibited by including the words “Dispense as Written”, or “No Substitution Allowed”, along with a statement that the brand name drug is medically necessary. A prescribing physician may also prohibit substitution of generic drugs by oral or electronic communication to the pharmacist so long as the same content is conveyed that is required in a written prescription.
 - (i) A bill or receipt for a prescription drug shall include all of the following:
 - (I) When a brand name drug with a generic equivalent is dispensed, the brand name and the generic name shall be included unless the prescriber indicates “do not label.”
 - (II) If the drug has no brand name, the generic name, and the manufacturer’s name or the supplier’s name, shall be included, unless the prescriber indicates “do not label.”
 - (III) The strength, unless the prescriber indicates “do not label.”
 - (IV) The quantity dispensed.
 - (V) The dosage.
 - (VI) The name, address, and federal tax ID# of the pharmacy.
 - (VII) The prescription number, if available.
 - (VIII) The date dispensed.

(Rule 0800-02-18-.12, continued)

- (IX) The name of the prescriber.
 - (X) The name of the patient.
 - (XI) The price for which the drug was sold to the purchaser.
 - (XII) The original manufacturer's National Drug Code Number ("NDC Number"), if one is available.
- (ii) The AWP shall be determined from the appropriate monthly publication. The monthly publication that shall be used for calculation shall be the same as the date of service. When an AWP is changed during the month, the provider shall still use the AWP from the monthly publication. The publications to be used are:
 - (I) Primary reference: Price Alert from Medi-Span, available online at the following web site: www.medi-span.com/Products/index.aspx?id+27.
 - (II) Secondary reference: (for drugs NOT found in PriceAlert) the Red Book from Medical Economics.
 - (iii) Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee as a result of the work-related injury.
 - (iv) A compounding fee not to exceed twenty-five Dollars (\$25.00) per compound prescription may be charged if two (2) or more prescriptive drugs require compound preparation when sold by a hospital or pharmacy.
 - (v) If a workers' compensation claimant chooses a brand-name medicine when a generic medicine is available and allowed by the prescriber, the claimant shall pay the difference in price between the brand-name and generic medicine and shall not be eligible to subsequently recover this difference in cost from the employer or carrier.
- (f) "Patent" or "Proprietary Preparations"
 - 1. "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for a work-related injury or illness instead of a legend drug.
 - 2. Generic substitution as discussed in (e) (2) above applies also to "over-the-counter" preparations.
 - 3. Pharmacists must bill and be reimbursed their usual retail price for the "over-the-counter" drug(s).
 - 4. The reimbursement formula does not apply to the "over-the-counter" drugs and no filling fee may be reimbursed.
 - (g) Dispensing Practitioner

(Rule 0800-02-18-.12, continued)

1. Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except such practitioners shall not receive a filling fee.
2. "Patent" or "proprietary preparations" frequently called "over-the-counter drugs," dispensed by a physician(s) from their office(s) to a patient during an office visit should be billed as follows:
 - (i) Procedure Code 99070 must be used to bill for the "proprietary preparation" and the name of the preparation, dosage and package size must be listed as the descriptor.
 - (ii) An invoice indicating the cost to the dispensing physician of the "proprietary preparation" must be submitted to the carrier with the HCFA 1500 Form or its successor form.
 - (iii) Reimbursement is limited to the lesser of the provider's billed charge or 20 percent above the actual cost to the dispensing physician of the item.

(h) Repackaged or Compounded Products

All pharmaceutical bills submitted for repackaged or compounded products must include the NDC Number of the original manufacturer registered with the U.S. Food & Drug Administration or its authorized distributor's stock package used in the repackaging or compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the product or ingredient, calculated on a per unit basis, as of the date of dispensing. A repackaged or compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If the original manufacturer's NDC Number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis. The filling fees otherwise provided in these Rules shall be payable when applicable.

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. 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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.13 AMBULANCE SERVICES GUIDELINES.

- (1) All non-emergency ground and air ambulance service provided to workers' compensation claimants shall be pre-certified. Emergency ground and air ambulance services may be retrospectively reviewed within three (3) business days.
- (2) All ground and air ambulance services shall be medically necessary and appropriate. Documentation, trip sheets, shall be submitted with the bill that states the condition that indicates the necessity of the ground and air ambulance service provided. It should readily indicate the need for transport via this mode rather than another less expensive form of transportation. The service billed shall be supported by the documentation submitted for review.

(Rule 0800-02-18, -.13, continued)

- (3) Billing shall be submitted to the employer or carrier on a properly completed HCFA 1500 form (or its successor form) by HCPCS code. Hospital based or owned providers must submit charges on a HCFA 1500 form (or its successor form) by HCPCS code.
- (4) Reimbursement shall be based upon the lesser of the submitted charge or 150% of the current Medicare rate. To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services.

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. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-18-.14 CLINICAL PSYCHOLOGICAL SERVICE GUIDELINES.

- (1) Reimbursement for psychological treatment services by any clinician other than a licensed psychiatrist shall be based on reasonableness and necessity and shall be reimbursed at 100% of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule). Treatment by a licensed psychiatrist shall be reimbursed as any other evaluation and management medical treatment under this Medical Fee Schedule.
- (2) Whenever such psychological treatment services exceed twelve (12) sessions/visits, then such treatment may be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-02-06 of the Division's Utilization Review rules before further psychological treatment services may be certified for payment by the carrier. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of psychological treatment services after the first twelve (12) sessions/visits shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional psychological treatment services as is appropriate.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 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 November 27, 2017; effective February 25, 2018.

0800-02-18-.15 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

- (1) Except when a waiver is 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 the Rules for Medical Payments, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules, unless otherwise provided by T.C.A. § 50-6-204. Any provider accepting and any employer or carrier paying an amount in excess of the Rules for Medical Payments, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, unless otherwise provided by T.C.A. § 50-6-204, shall be in violation of these Rules and may, at the Administrator's discretion, be subject to civil penalties whenever a pattern or practice of such activity is found, in accordance with the Uniform Rules of Procedure for Penalty Assessments and Hearing Contested Cases before the Bureau of Workers' Compensation 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

(Rule 0800-02-18-.15, continued)

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 violations of the Rules for Medical Payments, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules except as allowed by law shall subject the violator(s) to civil penalties in accordance with the Uniform Rules of Procedure for Penalty Assessments and Hearing Contested Cases before the Bureau of Workers' Compensation, at the discretion of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator.

- (2) A provider, employer or carrier found in violation of these Rules may request a contested case hearing by requesting such hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, notice of assessment of civil penalties. All rights, duties, obligations, and procedures applicable under the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., are applicable under these Rules, including, but not limited to, the right to judicial review of any final departmental decision.
- (3) The request for a hearing shall be made to the Bureau in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.
- (4) Any request for a hearing shall be filed with the Bureau within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty by the Administrator. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator being deemed 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 any 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 Penalty Program Rules, 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. Amendments filed November 27, 2017; effective February 25, 2018.