Rulemaking Hearing Rules
of
The Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation

Chapter 0800-2-18
Medical Fee Schedule

Rule Amendments

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The text of the amendments is as follows:

Amendments

0800-2-18-.02 General Information and Instructions for Use

Subparagraph (a) of paragraph (2) of rule 0800-2-18-02 General Information and Instructions for Use is amended by adding and inserting in after the third sentence which ends with the words "correct amount" the following: "For purposes of these Rules, the base Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but the maximum allowable amount of reimbursement under these Rules shall not fall below the effective 2005 Medicare amount for at least two (2) years from 2005," so that as amended the subparagraph shall read:

(a) Unless otherwise indicated herein, 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 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 most current effective CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. For purposes of these Rules, the base Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but the maximum allowable amount of reimbursement under these Rules shall not fall below the effective 2005 Medicare amount for at least two (2) years from 2005. 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 Medical Cost Containment Program Rules at 0800-2-17-.03(80).

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Part 3. of subparagraph (b) of paragraph (2) of rule 0800-2-18-02 General Information and Instructions for Use is amended by deleting the words "contracted or other lower price;" and adding in its place the words "other contracted price" so that as amended the part shall read:

3. The MCO/PPO or any other contracted price;

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Subparagraph (a) of paragraph (4) of rule 0800-2-18-02 General Information and Instructions for Use is amended by deleting the current subparagraph in its entirety and replacing it with a new subparagraph, so that as amended the subparagraph shall read:

(a) The conversion factors applicable under this Medical Fee Schedule are:

	Conversion Factor	As a Percentage of National Medicare
Anesthesiology	Usual and Customary Amount	
Chiropractic Care	$49.27	130%
Dentistry	$37.90	100%
General Surgery	$75.80	200%
Home Health Care	Usual and Customary Amount	
Home Infusion	Usual and Customary Amount	
Gen. Medicine (includes unlisted specialties, Evaluation & Management, etc.)		
Office visits, E&M, etc. CPT codes	$60.64	160%
Emergency care CPT codes	$75.80	200%
Neurosurgery (board-eligible or certified physicians)	$104.14	275%
(Surgery by non-board eligible physicians paid general surgery rate)		
Orthopedic Surg. (board-eligible or cert. physicians)	$104.14	275%
(Surgery by non-board eligible physicians paid general surgery rate)		
Pathology	Usual and Customary Amount	
Physical and Occupational Therapy		
Independently-owned Facilities-For First 6 visits	$56.85	150%
Visits 7-12	$49.27	130%
Visits over 12	$37.90	100%
Physician-affiliated Facilities-For First 6 visits	$49.27	130%
Visits 7-12	$39.79	105%
Visits over 12	$37.90	100%
Radiology	$75.80	200%

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Subparagraph (b) of paragraph (4) of rule 0800-2-18-.02 is amended by deleting the following at the end of the paragraph, "** 'LUPA' refers to the Medicare rates for low utilization Payment Adjustment," so that as amended the subparagraph shall read:

(b) The appropriate conversion factor must be determined by the type of CPT code for the procedure performed in all cases except those involving orthopedic and neurosurgery. The appropriate conversion factor for all surgical CPT codes for surgical procedures by any physician other than certified and board-eligible neurosurgeons and orthopedic surgeons is $75.80, (200% of national Medicare rates). Board-eligible and certified neurosurgeons and orthopedic surgeons shall use the neurosurgery and orthopedic surgery conversion factors for all surgery CPT codes. Evaluation

and management CPT codes require the use of the associated conversion factor of $60.64 (160% of National Medicare rates) by all physicians, including neurosurgeons and orthopedic surgeons.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-2-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges)

Subparagraph (b) of paragraph (1) of rule 0800-2-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges) is amended by deleting the following current language in the last sentence, "(subject to wage-price index adjustment)," so that as amended the subparagraph shall read:

(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 will be entitled.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Subparagraph (e) of paragraph (1) of rule 0800-2-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges) is amended by deleting the current language in its entirety and replacing it so that as amended the subparagraph shall read:

(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.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Subparagraph (h) of paragraph (1) of rule 0800-2-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges) is amended by deleting the current language in its entirety and adding a new subparagraph (1)(h), adding and inserting a new subparagraph (1)(i) and renumbering the current subparagraphs (1)(i), (1)(j), (1)(k) and (1)(l) so that as amended the subparagraphs shall read:

(h) Facility services do not include (the following services may be billed and reimbursed separately from the facility fees, if allowed under current Medicare guidelines, with the exception of implantables, which at the discretion of the facility shall be billed and reimbursed separately in all cases and in all settings unless they are billed and reimbursed as part of a package or bundled charge):

1. Physician services

2. Laboratory services

3. Radiology services

4. Diagnostic procedures not related to the surgical procedure

5. Prosthetic devices

6. Ambulance services

7. Orthotics

8. Implantables

9. DME for use in the patient's home

10. CRNA or Anesthesia Physician Services (supervision of CRNA is included in the facility fee)

11. Take home medications

12. Take home supplies

(i) For cases involving implantation of medical devices, the facility shall at their discretion for each individual patient case, choose to bill and shall subsequently be reimbursed at either:

1. 150% of the entire Medicare OPPS payment as described above; or

2. 150% of the non-device portion of the APC within the Medicare OPPS payment and separately bill and be reimbursed for implantable medical devices as described under Rule 0800-2-18-.10.

(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 without an appropriate Medicare payment amount and not specifically addressed in the Medical Fee Schedule Rules.

(k) There may be occasions in which the patient was scheduled for out patient surgery and it becomes necessary to admit the patient. All ambulatory patients who are admitted to the hospital and stay longer than 23 hours past ambulatory surgery will be paid according to the In-patient Hospital Fee Schedule Rules, Chapter 0800-2-19.

(l) 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. Pre-admission lab and radiology are not included in the facility fee.

(m) Facility fees for surgical procedures not listed shall be reimbursed BR with a maximum of the usual and customary rate as defined in the Division's Rule 0800-2-17-.03(80).

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-2-18-.09 Physical and Occupational Therapy Guidelines

Paragraph (1) of rule 0800-2-18-.09 Physical and Occupational Therapy Guidelines is amended by deleting the paragraph in its entirety and replacing it with the following new paragraph, so that as amended the paragraph shall read:

(1) Charges for physical and/or occupational therapy services shall be reimbursed on a bifurcated sliding scale based upon physician interest in the facility providing services. For the purpose of this Medical Fee Schedule, a "physician-affiliated" facility is one in which the referring physician has any type of financial interest, which includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect benefit of any kind, whether in money or otherwise, between the facility to whom the physician refers a person for services and that physician. Any hospital-based PT or OT facility shall also be deemed "physician-affiliated" if the referring physician is an employee of such hospital, or if he or she receives a benefit of any kind from the referral. All PT/OT services, wherever performed (hospital, freestanding facility, etc.) shall be reimbursed under this methodology.

(a) Independently-owned and operated facilities' reimbursement shall not exceed one hundred fifty percent (150%) of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule) for the first six (6) visits, and shall not exceed one hundred thirty percent (130%) for visits 7 through 12. For all visits after visit 12, reimbursement shall not exceed one hundred percent (100%).

(b) Physician-affiliated facilities' reimbursement shall not exceed one hundred thirty percent (130%) of the participating fees prescribed in the Medicare RBRVS System fee schedule for the first six (6) visits, and shall not exceed one hundred five percent (105%) for visits 7 through 12. For all visits after visit 12, reimbursement shall not exceed one hundred percent (100%).

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Paragraph (2) of rule 0800-2-18-.09 Physical and Occupational Therapy Guidelines is amended by adding the following after the word "scale" at the end of the first sentence: "based on the number of visits. The number of visits shall start over whenever surgery related to the injury is performed," so that as amended the paragraph shall read as follows:

(2) Charges for physical and/or occupational therapy services shall be reimbursed on a sliding scale based on the number of visits. The number of visits shall start over whenever surgery related to the injury is performed.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Paragraph (5) of rule 0800-2-18-.09 Physical and Occupational Therapy Guidelines is amended by adding additional language at the end of the paragraph so that as amended the paragraph shall read as follows:

(5) For any procedure for which an appropriate Medicare code is not available, such as a Functional Capacity Evaluation or work hardening, the usual and customary charge, as defined in Rule 0800-2-17-.03(80), shall be the maximum amount reimbursable for such services. The current Medicare CPT codes available for Functional Capacity Evaluations are not appropriate for use under the TN Workers' Compensation Medical Fee Schedule, thus, usual and customary is the proper reimbursement methodology for these procedures.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Paragraph (6) of rule 0800-2-18-.09 Physical and Occupational Therapy Guidelines is amended by deleting the current paragraph and replacing it with a new paragraph (6) so that as amended the paragraph shall read as follows:

(6) Whenever physical therapy and/or occupational therapy services exceed six (6) visits, or in cases which are post-operative, twelve (12) visits, such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within two (2) business days of any request for certification to assure no interruption in delivery of needed services. 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 physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

The rulemaking hearing rules set out herein were properly filed in the Department of State on the 8th day of January, 2007, and will become effective on the 24th day of March, 2007. (01-03-07)