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

Chapter 0800-2-17
Medical Cost Containment Program

New Rules

Table of Contents

0800-2-17-.01 Purpose and Scope
0800-2-17-.02 Severability and Preemption
0800-2-17-.03 Definitions
0800-2-17-.04 Information Program Involving Rules
0800-2-17-.05 Procedure Codes/Adoption of CMS' Medicare Procedures, Guidelines and Amounts
0800-2-17-.06 Procedures for Which Codes Are Not Listed
0800-2-17-.07 Modifier Codes
0800-2-17-.08 Total Procedures Billed Separately
0800-2-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case
0800-2-17-.10 Payment
0800-2-17-.11 Reimbursement for Employee-Paid Services
0800-2-17-.12 Recovery of Payment
0800-2-17-.13 Penalties for Violations of Fee Schedule Rules
0800-2-17-.14 Missed Appointment
0800-2-17-.15 Medical Report of Initial Visit & Progress Reports for Other than Inpatient Hospital Care
0800-2-17-.16 Additional Reports
0800-2-17-.17 Deposition/Witness Fee Limitation
0800-2-17-.18 Out-of-State Providers
0800-2-17-.19 Preauthorization
0800-2-17-.20 Utilization Review
0800-2-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills
0800-2-17-.22 Administrative Review of Fee Schedule Disputes/Hearings
0800-2-17-.23 Rule Review
0800-2-17-.24 Provider and Facility Fees for Copies of Medical Records

0800-2-17-.01 Purpose and Scope

(1) Purpose. Pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005), the following Medical Cost Containment Program Rules, together with the Medical Fee Schedule Rules, Chapter 0800-2-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-2-19.01 et seq., (collectively hereinafter "Rules") are hereby adopted by the Commissioner 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, to implement a medical fee schedule. The Commissioner promulgates these Rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). These Medical Cost Containment Program Rules must be used in conjunction with the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules. 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, carriers 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 Commissioner, the Commissioner's designee, or an agency member appointed by the Commissioner. These Rules are applicable only to those injured employees claiming benefits under the Tennessee Workers' Compensation Act, but are applicable in any state in which that employee seeks such medical benefits.

(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 receives a personal injury, or suffers an occupational disease, arising out of and in the course of employment, 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 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 cure, so far as reasonably and necessarily possible, and relieve from the effects of the 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. In no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the Commissioner's discretion, result in civil penalties of ten thousand dollars ($10,000.00) per violation each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, if a pattern or practice of such activity is found. At the Commissioner's discretion, 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.

(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 a carrier and the Division 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 a carrier 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) Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers which have excessive bills or which have required unjustified and/or unnecessary treatment, hospitalization, or visits.

(g) Permit review by the Division 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.

(h) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than the health care or service usually does with a diagnosis or condition for which the patient is being treated, the health care provider may be required by the carrier to explain the necessity in writing.

(i) Implement the Division's review and decision responsibility. These Rules and definitions are not intended to modify the workers' compensation laws, other administrative rules of the Division, or court decisions interpreting the laws or the Division's administrative rules.

(j) Establish maximum fees for depositions/witnesses.

(k) Establish maximum fees for medical reports.

(l) Provide for uniformity of billing for provider services.

(m) Establish the effective date for implementation of these Rules.

(n) Adopt by reference as part of these Rules the American Medical Association's CPT, Medical Fee Schedule Rules (Chapter 0800-2-18), the In-patient Hospital Fee Schedule (Chapter 0800-2-19) and any amendments to them.

(o) Establish procedures for reporting of medical claims.

(p) Establish procedures for utilization review of non-emergency hospitalizations, transfers between facilities, and outpatient services.

(q) Establish procedures for imposing and collecting civil penalties for violations of these Rules.

(r) The Rules shall become effective May 1, 2006.

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).

0800-2-17-.02 Severability and Preemption

If any provision of these Rules or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Rules and the application of the provisions to other persons or circumstances shall not be affected in any respect whatsoever. Whenever a conflict arises between these Rules and any other state rule or regulation, these Rules shall prevail.

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

0800-2-17-.03 Definitions. The following definitions are for the purposes of and are applicable to the Medical Cost Containment Program Rules (Chapter 0800-2-17), the Medical Fee Schedule Rules (Chapter 0800-2-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-2-19):

(1) "Act" means Tennessee's Workers' Compensation Act, Tenn. Code Ann. §§ 50-6-101 et seq., as amended.

(2) "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment such as:

(a) Applies the maximum fee allowable under these Rules;

(b) Applies an agreed upon discount to the provider's usual bill;

(c) Adjusts to a reasonable amount when the maximum fee is by report;

(d) Recodes a procedure;

(e) Reduces payment as a result of utilization review.

(3) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

(4) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner's designee after consultation with the Medical Director.

(5) "Bill" means a request by a provider submitted to a carrier for payment for health care services provided in connection with a compensable injury, illness or occupational disease.

(6) "Bill adjustment" means a reduction of a fee on a provider's bill.

(7) "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:

(a) Copies of operative reports.

(b) Consultation reports.

(c) Progress notes.

(d) Office notes or other applicable documentation.

(e) Description of equipment or supply (when that is the bill).

(8) “Carrier” means any stock company, mutual company, or reciprocal or inter-insurance exchange or self-insured employer authorized to write or carry on the business of workers’ compensation insurance in this state; whenever required by the context, the term ‘carrier’ shall be deemed to include duly qualified self-insureds or self-insured groups. Carrier is also deemed to mean any employer, should that employer not be insured for workers’ compensation as required by the Act.

(9) “Case” means a compensable injury, illness or occupational disease identified by the worker's name and date of injury, illness or occupational disease.

(10) “Case record” means the complete health care record maintained by the carrier pertaining to a compensable injury, illness or occupational disease and includes the circumstances or reasons for seeking health care; the supporting facts and justification for initial and continual receipt of health care; all bills filed by a health care service provider; and actions of the carrier which relate to the payment of bills filed in connection with a compensable injury, illness or occupational disease.

(11) “CMS” means the U.S. Centers for Medicare & Medicaid Services (formerly HCFA).

(12) “Commissioner” means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner’s designee, or an agency member appointed by the Commissioner.

(13) “Complete procedure” means a procedure containing a series of steps which are not to be billed separately.

(14) “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.

(15) “Compensable injury, illness or occupational disease” means an injury, illness or occupational disease for which health care treatment is mandated under Tennessee Workers’ Compensation Act.

(16) “CPT” means the most current edition of the American Medical Association’s Current Procedural Terminology.

(17) “Critical care” has the same meaning as that in the most current version of the CPT.

(18) “Day” means a calendar day, unless otherwise designated in these Rules.

(19) “Department” means the Tennessee Department of Labor and Workforce Development.

(20) “Diagnostic procedure” means a service which aids in determining the nature and cause of an occupational disease or injury.

(21) “Division” means the Workers’ Compensation Division of the Tennessee Department of Labor and Workforce Development.

(22) “Dispute” means a disagreement between a carrier or a carrier’s agent and a health care provider on interpretation or application of these Rules.

(23) “DRG” (Diagnosis Related Group) means one of the classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns as for Medicare purposes by CMS (see “HCFA”).

(24) “Durable medical equipment” or “DME” is equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness, injury or occupational disease, and (4) is appropriate for use in the home.

(25) “Established patient” has the same meaning as in the most current version of the CPT.

(26) “Expendable medical supply” means a disposable article which is needed in quantity on a daily or monthly basis.

(27) “Focused review” means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.

(28) “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, but does not include care for complications.

(29) “Follow-up days” means the days of care following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications.

(30) “Follow-up visits” means the number of office visits following a surgical procedure which is included in the procedure's maximum allowable payment, but does not include care for complications.

(31) “HCFA” (now the “CMS”) means the U.S. Centers for Medicare & Medicaid Services, formerly known as the Health Care Financing Administration of the U.S. Department of Health and Human Services.

(32) “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.

(33) “Health care review” means the review of a health care case or bill, or both, by a carrier, or the carrier's agent.

(34) “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.

(35) “Health Care Specialist service” means, in regard to the health care of a compensable injury, illness or occupational disease, the treatment by a health care specialist, when requested by the treating practitioner, carrier, or by the employee, and includes a history, an examination, evaluation of medical data, treatment, and a written report.

(36) “Inappropriate health care” means health care that is not suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner’s designee after consultation with the Division’s Medical Director.

(37) “Incidental surgery” means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the diagnosis.

(38) “Independent medical examination” means an examination and evaluation conducted by a practitioner different from the practitioner providing care, other than one conducted under the Division’s Medical Impairment Rating Registry (“MIRR”) Program.

(39) “Independent procedure” means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it.

(40) “Inpatient services” mean services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.

(41) “Institutional services” mean all non-physician services rendered within the institution by an agent of the institution.

(42) “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 Division’s Medical Fee Schedule. Bills in excess of the Division’s Medical Fee Schedule shall, at the Commissioner’s discretion, result in civil penalties of ten thousand dollars ($10,000.00) per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the Commissioner’s discretion, 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.

(43) “Maximum fee” means the maximum allowable fee for a procedure established by this rule, the Medical Fee Schedule and the In-patient Hospital Fee Schedule.

(44) “Medical admission” means any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.

(45) “Medically accepted standard” means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services and which may be defined in relation to any of the following:

(a) Professional performance.

(b) Professional credentials.

(c) The actual or predicted effects of care.

(d) The range of variation from the norm.

(46) “Medically appropriate care” means health care that is suitable for a particular person, condition, occasion, or place.

(47) “Medical Director” means the Division’s Medical Director appointed by the Commissioner pursuant to T.C.A. § 50-6-126 (Repl. 1999)

(48) “Medical only case” means a case which does not involve lost work time.

(49) “Medical supply” means either a piece of durable medical equipment or an expendable medical supply.

(50) “Modifier code” means a 2-digit number used in conjunction with the procedure code to describe unusual circumstances which arise in the treatment of an injured or ill employee.

(51) “New patient” means a patient who is new to the provider for a particular compensable injury, illness or occupational disease and who needs to have medical and administrative records established.

(52) “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.

(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.

(53) “Ophthalmologist” shall be defined according to T.C.A. § 71-4-102(3).

(54) “Optician” shall mean a licensed dispensing optician as set forth in T.C.A. § 63-14-103.

(55) “Optometrist” means an individual licensed to practice optometry.

(56) “Optometry” shall be defined according to T.C.A. § 63-8-102(12).

(57) “Orthotic equipment” means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.

(58) “Orthotist” means a person skilled in the construction and application of orthotic equipment.

(59) “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.

(60) “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, uncomplicated follow-up care/visits. This includes a standard postoperative period of 30 days.

(61) “Pattern or practice” means at least one (1) or more violations of the Medical Fee Schedule Rules, the Medical Cost Containment Rules (Chapter 0800-2-17) and/or the In-patient Hospital Fee Schedule Rules (Chapter 0800-2-19), have occurred after notice of a violation has issued from the Department for the first violation. To support civil penalties, such violations must be found to not have been inadvertent, as determined by the Commissioner.

(62) “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.

(63) “Practitioner” means a person licensed, registered, or certified as an audiologist, doctor of chiropractic, 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's assistant, prosthetist,

psychologist, or other person licensed, registered, or certified as a health care professional.

(64) "Preauthorization" means that the employer or carrier accepts the injured or disabled employee's injury or disease as compensable under the Act and authorizes payment of medical benefits under the Act. Preauthorization does not in any way include Utilization Review (defined below) and does not include any decision on the medical appropriateness or necessity of a medical service or treatment.

(65) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.

(66) "Procedure" means a unit of health service.

(67) "Procedure code" means a 5-digit numerical sequence or a sequence containing an alpha or alphas and followed by three or four digits, which identifies the service performed and billed.

(68) "Properly submitted bill" means a request by a provider for payment of health care services submitted to a carrier on the appropriate forms which are completed pursuant to this rule. Properly submitted bills shall include appropriate documentation as required by this rule.

(69) "Prosthesis" means an artificial substitute for a missing body part.

(70) "Prosthetist" means a person skilled in the construction and application of prosthesis.

(71) "Provider" means a facility, health care organization, or a practitioner.

(72) "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from but not limited to the provider, the carrier, or the Tennessee Workers' Compensation Division.

(73) "Reject" means that a carrier or a carrier's agent denies payment to a provider or denies a provider's request for reconsideration.

(74) "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.

(75) "Stop-Loss Payment" or "SLP" means an independent method of payment for an unusually costly or lengthy stay.

(76) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the Commissioner to be used as a multiplier to establish a reimbursement amount when total hospital bills have exceeded specific stop-loss thresholds.

(77) "Stop-Loss Threshold" or "SLT" means a threshold of bills established by the Commissioner, beyond which reimbursement is calculated by multiplying the applicable SLRF times the total bills identifying that particular threshold.

(78) "Surgical admission" means any hospital admission where there is an operating room bill, the patient with has a surgical procedure or ICD-9 code, or the patient has a surgical DRG as defined by the CMS.

(79) "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.

(80) "Usual and customary" means eighty-five percent (85%) of a specific provider's average bills to all payers for the same procedure or service.

(81) "UB-92, HCFA-1450, 1500 or CMS-1450" means the health insurance claim forms maintained for use by medical care providers and institutions.

(82) "Utilization Review" means evaluation of the necessity, appropriateness, efficiency and quality of medical care services provided to an injured or disabled employee based on 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 or a review of medical bills or fees.

(83) "Wage loss case" means a case that involves the payment of wage loss compensation.

(84) "Workers' Compensation Standard Per Diem Amount" or "SPDA" means a standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: T.C.A. §§ 50-6-102 and 50-6-204 (Repl. 2005).

0800-2-17-.04 Information Program Involving Rules

The Division may institute an ongoing information program regarding these Rules for providers, carriers, employees and employers. The program may include, at a minimum, informational sessions throughout the state, as well as the distribution of appropriate information materials.

Authority: T.C.A. §§ 50-6-102 and 50-6-204 (Repl. 2005).

0800-2-17-.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") and the Medicare RBRVS: The Physicians' Guide 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 the CMS.

(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 CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. The conversion amounts may, upon review by the Commissioner, be adjusted annually. 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 0800-2-17-.03(80) of this Chapter.

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

0800-2-17-.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. 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).

(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 as these services are reimbursed BR.

(3) Reimbursement by the carrier for BR procedures should be based upon the carrier's review of the submitted documentation, the recommendations from the carrier's medical consultant, and the carrier's review of the average bills for similar services as identified by the carrier based on data which is representative of Tennessee bills.

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

0800-2-17-.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 carrier. It is not appropriate to use Modifier 21, 22, or 25 for routine billing.

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

0800-2-17-.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 5-digit procedure code listed.

(a) When billing for the professional component only, Modifier 26 must be added to the appropriate 5-digit procedure code.

(b) When billing for the technical component only, Modifier TC (Technical Component) must be added to the appropriate 5-digit code.

Authority: T.C.A. §§ 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

0800-2-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case

(1) An independent medical examination, other than one conducted under the Division'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 Division'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 code 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 quarter hour, i.e. two and one-half hours may not exceed $1,250.00.

(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.

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

0800-2-17-.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 MCO/PPO or any other lower price. 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 carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) 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 most current edition of the Medicare RBRVS: The Physicians' Guide 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/medicare. Whenever a different guideline or procedure is not set forth in these Rules, the most current effective Medicare guidelines and procedures 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 0800-2-19.

(4) Billing for provider services shall be submitted on forms approved by the Division, UB-92 and CMS-1500, or their official replacement forms.

(5) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.

(6) A carrier's payment shall reflect any adjustments in the bill.

(a) A carrier must provide an explanation of medical benefits to a health care provider whenever the carrier's reimbursement differs from the amount billed by the provider.

(b) A provider shall not attempt to collect from the injured employee, employer, or carrier any amounts properly reduced by the carrier.

(7) 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 HIPPA requirements.

(8) A carrier shall date stamp medical bills and reports upon receipt and shall pay an undisputed and properly submitted bill within thirty-one (31) calendar days of receipt. Any carrier that fails to pay an undisputed and properly submitted bill within thirty-one

31 calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% annual percentage rate ("APR")). The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.

(9) When a carrier disputes a bill or portion thereof, the carrier shall pay the undisputed portion of the bill within thirty-one (31) calendar days of receipt of a properly submitted bill. Any carrier not paying an undisputed portion of the bill within thirty-one (31) calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% APR)on the undisputed portion of the bill. The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.

(10) Any provider not receiving timely payment of the undisputed portion of the provider's bill may institute a collection action in a court having proper jurisdiction over such matters to obtain payment of the bill, together with the interest civil penalty of 25% APR. Such providers, if they prevail, shall also be entitled to reasonable costs and attorney fees incurred in such collection actions to be paid by the carrier or self-insured 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 for correction and resubmission. If a carrier returns such billings, it must do so within 20 calendar days of receipt of the bill. The number of days between the date the carrier returns the billing to the provider and the date the carrier receives the corrected billing, shall not apply toward the thirty-one (31) calendar days within which the carrier is required to make payment.

(12) Payments to providers for initial examinations and treatment authorized by the carrier or a self-insured employer shall be paid by that carrier or self-insured employer and shall not later be subject to reimbursement by the employee or another medical insurance program, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

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

0800-2-17-.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 a carrier is determined to be responsible for the payment, then the employee shall be fully reimbursed by the carrier.

Authority: T.C.A. §§ 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

0800-2-17-.12 Recovery of Payment

(1) 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.

(2) A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one year of the date of payment. A provider may likewise recover additional payment from any carrier with a statement of reasons for the request, within one year of the date of service.

(3) Within thirty-one (31) calendar days of receipt of the carrier's or provider's request for recovery of the payment, the provider or carrier shall do either of the following:

(a) If in agreement with the request, the provider shall refund payment to the carrier, or in the case of a provider requesting additional payment, the carrier shall submit payment to the provider;

(b) If not in agreement with the request, supply the carrier or provider with a written detailed statement of the reasons for the disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded, or payment of the amount the carrier agrees should be paid to the provider.

(4) If the carrier or provider does not accept the reason for disagreement supplied by the adverse party, the carrier or provider may file a request for Administrative Review, within thirty-one (31) calendar days of receipt of the provider's statement of disagreement. The request for review shall be filed with the Medical Director for a recommendation by the Medical Care and Cost Containment Committee ("MCCCC"). The complaining party shall supply a copy to the opposing party.

(5) If, within 62 calendar days of the provider or carrier's request for recovery of a payment, the carrier or provider does not receive either a full refund of the payment (or full payment in the case of providers) or a statement of disagreement, then, at the option of the carrier or provider, the carrier or provider may do the following:

(a) File a request for Administrative Review as outlined above, of which the complaining party shall supply a copy to the opposing party.

(b) If a carrier, then reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.

(6) If, within thirty-one (31) calendar days of a recommendation from the MCCCC, the amount recommended is not paid, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment, plus an additional 25% per annum. A provider may also add the additional 25% per annum to the amount recommended to be paid by the MCCC. The provider or carrier may, at its discretion, pursue recovery of the refund or, in the case of providers, additional payment, in a court of law with proper jurisdiction pursuant to Tenn. Code Ann. § 50-6-226.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-226 and 50-6-233 (Repl. 2005).

0800-2-17-.13 Penalties for Violations of Fee Schedule Rules

(1) Providers shall not accept and employers or carriers 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 Medical Cost Containment Program Rules, Medical 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 or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars ($10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) 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 Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, 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 Medical Cost Containment Program 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 one hundred dollars ($100.00) nor more than ten thousand dollars ($10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.

(2) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting the hearing in writing within fifteen (15) calendar 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 Division within the fifteen (15) calendar days of issuance of the Notice of Violation, the determination of such violation shall be deemed a final order of the Department and not subject to further review. 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) A request for hearing shall be made to the Division in writing by an employer, carrier or provider notified of violation of these Rules.

(4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar 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) calendar days of the date of issuance of the Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.

(5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner 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 Division's Penalty Program Rules, Chapter 0800-2-13, shall apply and be followed in any such contested case hearing.

(6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

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).

0800-2-17-.14 Missed Appointment

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the Division, the carrier, the carrier's case manager or the employer. If the carrier, carrier's 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 carrier or employer for the missed appointment using 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. 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).

0800-2-17-.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 carrier 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, and a progress report for every 60 calendar days of continuous treatment for the same compensable injury, illness or occupational disease.

(2) If the provider continues to treat an injured or ill employee for the same compensable injury, illness or occupational disease at intervals which exceed 60 calendar days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 calendar days.

(3) The narrative medical report of the initial visit and the progress report shall include 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 if applicable.

(4) Cost of these narrative medical reports required by 0800-2-17-.15(1) and (2) 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. Under no circumstances shall a provider bill for more than one report per visit. Initial reports shall billed using procedure code WC101, subsequent reports shall billed using procedure code WC102, and all final reports shall billed using procedure code WC103. No charge is allowed for routine office notes as these are not considered narrative reports under this Rule.

(5) A medical provider shall not bill any fee for completing a medical report form required by the Division.

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

0800-2-17-.16 Additional Reports

Nothing in this rule shall preclude a carrier or an employee from requesting reports from a provider in addition to those specified in Rule 0800-2-17-.15.

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

0800-2-17-.17 Deposition/Witness Fee Limitation

(1) Any provider who gives a deposition shall be allowed a witness fee.

(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 Division Rule 0800-2-16-.01, and shall be subject to penalties under these Rules for charging any amount which exceeds that amount.

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

0800-2-17-.18 Out-of-State Providers

All medical services provided by out-of-state providers must be made by providers who agree to abide by the Division's Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules and Medical Cost Containment Program Rules.

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

0800-2-17-.19 Preauthorization

(1) Preauthorization shall be required for all non-emergency hospitalizations, non-emergency transfers between facilities, and non-emergency outpatient services. Decisions regarding

authorization must be communicated to the requesting provider within seven (7) business days. Failure to provide a timely decision within seven (7) business days shall result in the authorization being deemed approved. Preauthorization is the determination of whether the injury is recognized as compensable and whether a service or treatment is related to the compensable injury or occupational disease such that the carrier authorizes the treatment. Preauthorization does not involve utilization review.

(2) Any decision of denial for payment for any type of health care service and/or treatment resulting from utilization review, as opposed to preauthorization, shall only be made by an agent of a utilization review company properly approved by the Tennessee Department of Commerce and Insurance, as prescribed in Division Rule 0800-2-6-.02.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

0800-2-17-.20 Utilization Review

(1) Scope of this part:

(a) Requirements contained in this part pertain to Utilization Review activity as defined by Tenn. Code Ann. § 50-6-102(18) (Repl. 2005) with respect to services by a provider for health care or health related services furnished as a result of a compensable injury, illness or occupational disease arising out of and in the course of employment. Notwithstanding any other provision in these Rules, these Rules are intended to supplement and do not in any way displace the Division's Utilization Review Rules, Chapter 0800-2-6.

(2) Carrier's Utilization Review Program:

(a) All carriers shall have a utilization review program.

(b) Upon all emergency hospital admissions, utilization review must begin within 24 hours or the next business day of such admission.

(c) Utilization review shall be conducted through pre-admission review of all hospital admissions and shall be ongoing under such circumstances.

(d) Utilization review shall be conducted in each case in which the cumulative medical costs exceed $5,000.00.

(e) Under the utilization review program, the carrier shall do all of the following:

1. Perform ongoing utilization review of medical bills to identify over-utilization of services;

2. Refer to the Division's Medical Director all providers whose billing practices indicate over-utilization.

3. A carrier may have another certified entity perform utilization review activities on its behalf.

(f) The utilization review program, whether operated by the carrier or an entity on behalf of the carrier, shall be certified by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.

(g) The carrier shall provide the Division with the name, address, and license number (and a copy of the contract agreement between the carrier and other entity if applicable) of the entity responsible for conducting the carrier's utilization review program.

(h) The carrier is responsible for notifying the Division when changing reviewing entities.

(i) For purposes of this rule, a carrier which has another entity perform utilization review activities on its behalf maintains full responsibility for compliance with this rule.

(j) Under the carrier's utilization review program, the carrier shall make determinations concerning the compensable injury, illness or occupational disease through one of the following approaches:

1. Review by licensed, registered, or certified health care professionals.

2. The application of criteria developed by licensed, registered, or certified health care professionals.

3. A combination of approaches in subdivisions (1) and (2) of this Subsection according to the type of covered injury or illness.

(k) Licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.

(l) These licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

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).

0800-2-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills

(1) Carrier's Dispute of a Bill

(a) When a carrier adjusts and/or disputes a bill or portion thereof, the carrier shall notify the provider within thirty-one (31) calendar days of the receipt of the bill of the specific reasons for adjusting and/or disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action.

(b) If the provider sends a bill to a carrier and the carrier does not respond in thirty-one (31) calendar days, and if a provider sends a second bill and receives no response within 62 calendar days from the date the provider supplied the first bill, the provider may then proceed with whatever collection actions it deems appropriate in a court of law with proper jurisdiction.

(c) The carrier shall notify the employer, employee and the provider that the rules prohibit a provider from billing an employee, employer, or carrier for any amount for health care services provided for the treatment of a compensable work-related injury, illness or occupational disease when that amount is disputed by the carrier pursuant to its utilization review program, or when the amount exceeds the maximum allowable payment established by the Fee Schedule Rules (Medical and In-patient Hospital). The carrier shall request the employee to notify the carrier if the provider so bills the employee, or employer.

(2) Provider’s Request for Reconsideration of Bill

A provider may request reconsideration of its adjusted and/or disputed bill by a carrier within thirty-one (31) calendar days of receipt of a notice of an adjusted and/or disputed bill or portion thereof. The provider's request to the carrier for reconsideration of the adjusted and/or disputed bill shall include a statement in detail of the reasons for disagreement with the carrier's adjustment and/or dispute of a bill or portion thereof.

(3) Carrier’s Response to Provider’s Request for Reconsideration of Bill; Provider’s Right to Appeal:

(a) Within thirty-one (31) calendar days of receipt of a provider’s request for reconsideration, the carrier shall notify the provider of the actions taken and a detailed statement of the reasons. The carrier’s notification shall include an explanation of the appeal process provided under this rule.

(b) If a provider is disagrees with the action taken by the carrier on its request for reconsideration, the provider may file a request for Administrative Review within thirty-one (31) calendar days from the date of receipt of a carrier’s denial of the provider’s request for reconsideration, and the provider shall supply a copy to the carrier.

(c) If within sixty-two (62) calendar days of the provider’s request for reconsideration, the provider does not receive payment for the adjusted and/or disputed bill or portion thereof, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may make application for Administrative Review by the Medical MCCCC.

(4) Disputes

(a) Unresolved disputes between a carrier and provider concerning bills and/or 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 presented to the Medical Care and Cost Containment Committee. A request for Administrative Review may be submitted to: Medical Director of the Workers' Compensation Division, Tennessee Department of Labor and Workforce Development 710 James Robertson Parkway, Andrew Johnson Tower, 2nd Floor Nashville, Tennessee 37243.

(b) Valid requests for Administrative Review do not require a particular form but must be legible and 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 the specific reimbursement.

3. Supporting documentation and correspondence, if any.

4. Specific information regarding contact with the carriers.

5. A verified or declared written medical report signed by the physician.

6. A specific written request for Administrative Review.

(c) The party requesting Administrative 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.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226 and 50-6-233 (Repl. 2005).

0800-2-17-.22 Administrative Review of Fee Schedule Disputes/Hearings

(1) Administrative Review Procedure

(a) When a request for Administrative Review by the MCCCC is received by the Division's Medical Director, the parties will be notified when the MCCCC will consider the dispute.

(b) The MCCCC shall consider the dispute and issue its recommendation as to the proper resolution of the dispute.

(c) If the parties to the dispute do not follow the recommendation of the MCCCC, then either party may proceed in any court of law with proper jurisdiction to decide the dispute.

(2) Computation of Time Periods

(a) 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 holiday by the President or Congress of the United States or so designated by the laws of this State.]

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

0800-2-17-.23 Rule Review

The Division encourages participation in the development of and changes to the Medical Cost Containment Program Rules, the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules by all groups, associations, and the public. Any such group, association or other party desiring input into or changes made to these Rules and associated schedules must make their recommendations, in writing, to the Commissioner. After analysis, the Division may incorporate such recommended changes into Rules after appropriate consideration, public comment and compliance with the Uniform Administrative Procedures Act regarding promulgation of rules. The Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules shall be reviewed by the Commissioner, in consultation with the Medical Care and Cost Containment Committee and the Advisory Council on Workers' Compensation, on an annual basis. When appropriate, the Commissioner may revise these Rules as necessary and appropriate.

Authority: T.C.A. § 50-6-204 (Repl. 2005).

0800-2-17-.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 carrier, self-insured employer, employee, attorneys, etc. Documentation which is submitted by the provider and/or facility, but was not specifically requested by the carrier, shall not be allowed a copy charge.

(2) Health care providers and facilities must furnish an injured employee or the employee's attorney and carriers/self-insureds or their legal representatives copies of records and reports upon request. The maximum charge allowed shall be the same as that set out in Tenn. Code Ann. § 50-6-204, as amended.

(3) Health care providers and facilities may be reimbursed up to the usual and customary amount, as defined in these Rules at 0800-2-.03(80), 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.

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 3rd day of February, 2006, and will become effective on the 19th day of April, 2006.