

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

Chapter 0800-2-18
Medical Fee Schedule

New Rules

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0800-2-18-.01 Medicare-basis for System, Applicability, Effective Date and Coding References

- (1) The Medical Fee Schedule of the Tennessee Division of Workers' Compensation ("TDWC") is a Medicare-based system, but with multiple conversion factors. 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's) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' national relative value units and Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation in these Rules. These Medical Fee Schedule Rules must be used in conjunction with the most current American Medical Association's ("AMA's") CPT Code Guide, the Health Care Financing Administration Common Procedure Coding System ("HCPCS"), the most current and effective AMA's Medicare RBRVS: The Physicians' Guide, the American Society of Anesthesiologists ("ASA") Relative Value Guide, and the most current effective Medicare procedures and guidelines.
- (2) These Medical Fee Schedule Rules must also be used in conjunction with Medical Cost Containment Program Rules, Chapter 0800-2-17, and the In-patient Hospital Fee Schedule Rules, Chapter 0800-2-19. 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 are effective May 1, 2006 and apply to all services provided on or after May 1, 2006. The most current 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.

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

0800-2-18-.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 Medical Cost Containment Program Rules, and the In-patient Hospital Fee Schedule Rules, if applicable.

(2) Reimbursement

- (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. 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).

- (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 TDWC 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 contracted or other lower price;
4. In no event shall reimbursement be in excess of these TDWC Fee Schedule Rules, unless otherwise provided in the Division's rules. Reimbursement in excess of the TDWC Medical Fee Schedule Rules may result in civil penalties, at the Commissioner's discretion, of \$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, 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 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 ninety (90) calendar days that constitutes a violation by a provider. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board or other appropriate authority, and may be subject to exclusion from participating further in providing care under the Tennessee Workers' Compensation Act ("Act").

5. 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 ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. If such amount is refunded/recovered within this ninety (90) calendar day time period, the overpayment shall not be considered a violation of these Rules by the provider/carrier and shall not be the basis for a penalty against the provider receiving or carrier paying the excessive payment.

(3) Fee Schedule Calculations

- (a) The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT code by multiplying the national total relative value units ("RVUs"), unadjusted for the Geographic Practice Cost Indexes ("GPCIs"), by the appropriate conversion factor. Whether one uses the facility or nonfacility total RVU amount must be determined using the most current, effective Medicare guidelines 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 Medical Cost Containment Rules at 0800-2-17-13(80)), as indicated. For areas not listed, the maximum allowable amount is 100% of the Medicare allowable amount calculated in accordance with Medicare guidelines and methodology.

- (4) Monetary Conversion Factors are based on the CMS' 2006 unit amount of \$37.8975. These Factors are subject to change based upon any change in the Medicare unit amount.

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

	<u>Conversion Factor</u>	<u>As a Percentage of National Medicare</u>
Anesthesiology.....		Usual and Customary Amount
Chiropractic Care.....	\$49.27	130%
Dentistry.....	\$37.90	100%
General Surgery.....	\$75.80	200%
Home Health Care.....		100% of Medicare's LUPA*

	<u>Conversion Factor</u>	<u>As a Percentage of National Medicare</u>
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) (Surgery by non-board eligible physicians paid general surgery rate)	\$104.14	275%
Orthopedic Surg. (board-eligible or cert. physicians) (Surgery by non-board eligible physicians paid general surgery rate)	\$104.14	275%
Pathology.....		Usual and Customary Amount
Physical and Occupational Therapy		
	For First 6 visits \$56.85	150%
	Visits 7-12 \$49.27	130%
	Visits over 12... \$37.90	100%
Radiology	\$75.80	200%

- (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.

*“LUPA” refers to the Medicare rates for Low Utilization Payment Adjustment.

(5) Forms

- (a) The following forms (or their official replacements) should be used for provider billing: CMS 1500 and UB 92
- (b) Bills for reimbursement shall be sent directly to the party responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Insurance Carriers and/or Employers shall furnish this information to the Providers.

(6) Violations of Fee Schedule Rules and Medical Cost Containment Rules

- (a) The Commissioner, Commissioner’s Designee, or an agency member appointed by the Commissioner, shall have the authority to issue civil penalties up to and including \$10,000.00 per violation for violations of the Medical Fee Schedule

Rules, In-patient Hospital Fee Schedule Rules or the Medical Cost Containment Program Rules (“Rules”) as prescribed in the Rules. Any party notified of an alleged violation, whether or not they are assessed civil penalties hereunder, shall be entitled to a contested case hearing before the Commissioner, Commissioner’s Designee, or an agency member appointed by the Commissioner pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., if a written request is submitted to the Division 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.

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

0800-2-18-.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 most current effective editions of the AMA’s CPT Guide and Medicare RBRVS: The Physicians’ Guide apply 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. CDT-3 Codes of current dental terminology prescribed by the American Dental Association, including the terminology updates and revision 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’s CPT and the Medicare RBRVS: The Physicians’ Guide, the following Medical Fee Schedule Rule Guidelines also apply. Whenever a conflict exists between these Medical Fee Schedule Rules and any other state fee schedule, rule or regulation, these Rules shall govern.

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

0800-2-18-.04 Surgery Guidelines

- (1) Multiple Procedures: Reimbursement shall be based on 100% of the physician’s usual charge for the major procedure (not to exceed 100% of the TDWC Medical Fee Schedule amount allowable) plus 50% of the physician’s usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the TDWC Medical Fee Schedule allowable).
- (2) Services Rendered by More Than One Physician:
 - (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. Duly licensed physician assistants 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 that would be due under Medicare guidelines, without regard for conversion factors contained in the workers' compensation Medical Fee Schedule.

- (c) 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 carrier has received each surgeon's individual operative report and bill. Reimbursement to both surgeons shall not exceed 150% of the maximum allowable Fee Schedule amount of the first surgeon and shall be allocated between the surgeons as agreed by them.
- (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. 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.
- (5) 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).

0800-2-18-.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 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. To order the Relative Value Guide, write to the American Society of Anesthesiologists, 520 N Northwest Highway; Park Ridge, IL 60068-2573, or call (847) 825-5586.
 - (b) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the usual and customary charge. No payment will be made to the surgeon supervising the CRNA.
 - (c) When anesthesia is administered personally by an anesthesiologist or administered by a care team involving an anesthesiologist and CRNA, reimbursement shall not exceed 100% of the provider's usual and customary charge.

(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.
- (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 or any fraction thereof equals one (1) time unit. For example, 71 minutes of anesthesia time would have the following time units: $71/15 = 5$ Time Units.
 - 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. The TAV is calculated for the purpose of determining reimbursement.

(4) Billing

- (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. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form.

(5) Reimbursement

- (a) Reimbursement for anesthesia services must be no more than the provider's usual and customary charge.

- (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 documents extreme emergency situations. Reimbursement shall not exceed the provider's usual and customary charge.
- (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
1. When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, the surgeon may be reimbursed for the anesthesia service in addition to the surgical procedure.
- (i) To identify the anesthesia service, list the CPT surgical procedure code and add Modifier 47.
- (ii) Reimbursement shall not exceed the provider's usual and customary charge.
- (iii) The operating surgeon must not use the diagnostic or therapeutic nerve block codes to bill for administering regional anesthesia for a surgical procedure.
- (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 BR.
- (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.

- (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).

0800-2-18-.06 Injections Guidelines

Reimbursement for injection(s) (such as J codes) includes allowance for CPT code 90782. In cases where multiple drugs are given as one injection, only one administration fee is owed. 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”).

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)

- (1) When medically appropriate, surgical procedures may be performed on an outpatient basis to reduce unnecessary hospitalization and to shift care to a less costly setting.
 - (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 (subject to wage-index adjustment) to which an ASC or hospital will be entitled.
 - (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 encounter. When multiple surgical procedures are performed during the same surgical session, the

reimbursement shall be made at 100% of the appropriate rate for the highest charge surgical procedure and 50% of the appropriate rate for all additional surgical procedures. Only separate and distinct surgical procedures shall be billed. Medicare guidelines shall be consulted and used in determining separate and distinct surgical procedures.

- (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) Adjustments for differences in wages across geographic areas shall be made to determine the base APC amount using the inpatient hospital PPS wage index (post-reclassification, post floor). It is estimated that 60% of the group payment represents labor-related costs and are subject to the geographic adjustment. Refer to the CMS web site at: <http://www.cms.hhs.gov/HospitalOutpatientPPS> to locate the appropriate wage index.
- (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 85% of the billed charges, as defined in the Division's Rule 0800-2-17-.03(80).
- (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) Facility services do not include (the following may be billed and reimbursed separately from the facility fees, if allowed under current Medicare guidelines, with the exception of implantables, which shall be reimbursed separately in all cases and in all settings unless they are 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) 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.
 - (j) 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, 0800-2-19.
 - (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. Pre-admission lab and radiology are not included in the facility fee.
 - (l) 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-.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 0800-2-18-.09(5) below apply to chiropractic services, except that the thirty (30) calendar day time period therein shall not apply to chiropractic services.
- (2) For chiropractic services, an office visit shall not be billed on the same day as a manipulation is billed.
- (3) If allowable payment for chiropractic services is not paid by employers or insurers for chiropractic services provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) calendar days from the date of receipt by the employer or insurer of the bill for chiropractic services provided to such an employee, interest at the rate of 25% per annum of the payment allowed pursuant to these rules, compounded monthly, may be charged and paid as set forth in Rule 0800-2-17-.10 of the Medical Cost Containment Program Rules.
- (4) 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.

- (5) 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.

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

- (1) It shall be a violation of these Rules, and may result in a civil penalty of \$10,000.00 per violation, as determined by the Commissioner, for any physician to refer a patient to a "physician-affiliated" facility for physical therapy or occupational therapy. For the purpose of these Medical Fee Schedule Rules, a "physician-affiliated" facility is one in which the referring physician (or her or his immediate family, which includes spouses, parents, children or spouses of children of the referring physician) or any of the referring physicians' partners associated together in clinical practice has any type of financial interest, which includes, but is not limited to, any type of ownership, interest, debt, loan, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or any other form of direct or indirect benefit of any kind, whether in money or otherwise. Any hospital-based PT or OT facility shall also be deemed "physician-affiliated" if the referring physician is an employee of such hospital in which the facility is located, or if he or she receives a benefit of any kind from the referral.
 - (a) Notwithstanding any provision to the contrary, an orthopedic or neurosurgeon may refer a patient to a physician-affiliated facility if that orthopedic or neurosurgeon has performed orthopedic or neurological surgery on such patient and that physician determines it is in the patient's best interest to refer the patient to a specific physician-affiliated facility for rehabilitation from such surgery. A physician may also refer a patient to a physician-affiliated facility if there is no other physical or occupational facility within fifteen (15) miles of that patient's residence or of the referring physician's office.
- (2) Charges for physical and/or occupational therapy services shall be reimbursed on a sliding scale. 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%).
- (3) For physical therapy and/or occupational therapy, 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.
- (4) For physical therapy and/or occupational therapy, 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.
- (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.
- (6) Whenever physical therapy and/or occupational therapy services exceed twelve (12) sessions/visits or a period over thirty (30) calendar days, whichever comes first, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in Chapter 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 utilization review shall be completed within seven (7) business days of the request for utilization review to assure no interruption in delivery of needed services. Failure of a provider to promptly (at least seven (7) business days before the last approved treatment is rendered) and properly request utilization review of such services as prescribed herein shall result in the forfeiture of any payment for non-approved services. However, failure by carrier to communicate denial or approval of a properly submitted request for utilization review within seven (7) business days of receipt of the request shall be deemed an approval of any further treatment requested. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of sessions/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).

0800-2-18-.10 Durable Medical Equipment and Implant Guidelines

(1) Reimbursement for durable medical equipment and implants for which billed charges are \$100.00 or less shall be limited to eighty-five (85%) of billed charges. Durable medical equipment and implants for which billed charges 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 implants are in addition to, and shall be billed separately from, all facility and professional service fees. Codes to be used are found in the HCPCS. Charges should be submitted on a HCFA 1500 form.

(a) 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.

(b) Rental/Purchase. Rental fees are applicable in instances of short-term utilization (30-60 days). 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".

(c) 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.

1. Rentals

(i) Include the following supplies:

(I) lead wires;

(II) two (2) rechargeable batteries;

- (III) battery charger;
- (IV) electrodes; and
- (V) instruction manual and/or audio tape.

- (ii) Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and “BR”
- (iii) Limited to 30 days trial period.

2. Purchase:

- (i) 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?
- (ii) 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) a battery charger.
- (iii) Only the first month’s rental price shall be credited to purchase price.
- (iv) Provider shall indicate TENs manufacturer, model name, and serial number.

- (d) Continuous and Passive Motion (Use Code D0540)

1. Use of this unit in excess of 30 days requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.

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

0800-2-18-.11 Orthotics and Prosthetics Guidelines

- (1) Orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System (HCPCS). Copies may be obtained from the American Orthotic and Prosthetic Association, 1650 King Street, Suite 500, Alexandria, VA 22314, (703) 836-7116. Orthotics and prosthetics shall be reimbursed up to a maximum of 115% of the national Medicare allowable amount and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from, all 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 a HCFA or CMS 1500 form.

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

0800-2-18-.12 Pharmacy 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 subsection (5) of this section.
 - (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.
 4. For the purposes of these TWCD 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 and dispensing practitioners) is the lesser of:
 - (i) Average Wholesale Price* (“AWP”) + \$5.10 filling fee;
 - (ii) the provider’s usual charge; or,
 - (iii) a negotiated contractual or other lesser amount.

* The Commissioner may at any time adopt and implement a different base price other than AWP (such as average sales price), should medical reimbursement standards and/or local or other practices warrant, at the Commissioner’s discretion.

2. 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 charge 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” in the prescriber’s own handwriting, 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.
 - (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 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, pharmacy, or provider of service other than a physician.
- (v) If allowable payment for prescriptive drugs is not paid by employers or carriers for prescriptions provided to employees who have suffered a compensable work-related injury under the Workers’ Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for prescriptive drugs provided to such an employee, interest at the rate of 2.08% /month of the payment allowed pursuant to these rules may be charged by a hospital, pharmacy, or provider of such service as set forth in Rule 0800-2-11-.10 of the Medical Cost Containment Program Rules.
- (vi) 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 (4)(b) above applies also to "over-the-counter" preparations.
3. Pharmacists must bill and be reimbursed their usual and customary charge 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

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.
 - (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.

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

0800-2-18-.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 shall be retro-certified within 72 hours of the service or 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.

- (3) Billing shall be submitted to the employer or carrier on a properly completed HCFA or CMS 1500 claim form by HCPCS code. Hospital based or owned providers must submit charges on a HCFA or CMS 1500 form by HCPCS code.
- (4) Reimbursement shall be based upon the lesser of the submitted charge or the average reimbursement rate for ambulances within the geographic locality. These charges shall not exceed the average charges in that locality for comparable services under comparable circumstances and commensurate with the services actually performed. Ambulance services shall be paid on a two (2) part basis, the first level being the level of care, the second being a mileage allowance. The services rendered are independent of the type of call received.

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

0800-2-18-.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 fifteen (15) sessions/visits, then 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 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 fifteen (15) 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).

0800-2-18-.15 Penalties for Violations of Fee Schedules

- (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 TDWC 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 in violation of these Rules, whether a civil penalty is assessed or not, 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 Division 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 Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty by the Commissioner. 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 Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner being deemed 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 any 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. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Legal contact and/or party who will approve final copy for publication:

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Signature of the agency officer or officers directly responsible for proposing and/or drafting these rules:

E. Blaine Sprouse, Attorney
Division of Workers' Compensation
Tenn. Dept. of Labor & Workforce Dev.

I certify that this is an accurate and complete copy of rulemaking hearing rules lawfully promulgated and adopted by the Tennessee Department of Labor and Workforce Development on the _____ day of _____, 2006.

Further, I certify that the provisions of Tenn. Code Ann. § 4-5-222 have been fully complied with, that these rules are properly presented for filing, a notice of rulemaking hearing has been filed in the Department of State on the 20th day of July, 2005 and such notice of rulemaking hearing having been published in the August, 2005 issue of the Tennessee Administrative Register, and such rulemaking hearing having been conducted pursuant thereto on the 23rd day of September, 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.