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Revision Type (check all that apply):
x Amendment
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables. Please enter only **ONE** Rule Number/RuleTitle per row)

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0800-02-19-.04	Pre-admission Utilization Review
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(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Rule Amendments

Chapter 0800-02-17
Medical Cost Containment Program

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Rule 0800-02-17-.01 Purpose and Scope, paragraph (1) is amended by adding a hyphen in the citation to Rule 0800-2-19-.01, so that the new rule will read as follows:

(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.

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).

Rule 0800-02-17-.01 Purpose and Scope, paragraph (2), subparagraph (c) is amended by adding the words "up to" in the third sentence before the words "ten thousand dollars", so that the new rule will read as follows:

(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 up to 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.

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).

Rule 0800-02-17-.03 Definitions, paragraph (42) is amended by adding the words "up to" before the words "ten thousand dollars" in the third sentence, so that the new rule will read as follows:

(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 up to 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.

Authority: T.C.A. §§ 50-6-102, 50-6-204 and 50-6-233 (Repl. 2005).

Rule 0800-02-17-.03 Definitions, paragraph (78) is amended by deleting the word "with" between the words "patient" and "has", so that the new rule will read as follows:

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

Authority: T.C.A. §§ 50-6-102, 50-6-204 and 50-6-233 (Repl. 2005).

Rule 0800-02-17-.05 Procedure Codes/Adoption of the CMS' Medicare Procedures, Guidelines and Amounts, paragraph (4) is amended by adding the phrase ", subject to the requirements of Rule 0800-02-18-.02(4)" after the word "amount" in the second sentence, so that the new rule will read as follows:

(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, subject to the requirements of Rule 0800-02-18-.02(4). 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).

Rule 0800-02-17-.07 Modifier Codes is amended by adding a new paragraph (4) at the end, which will read as follows:

(4) The maximum allowable additional amount under these Rules for Modifier 22 is 10%; provided that such maximum shall only apply to those board certified or eligible physicians performing neurosurgery or orthopedic surgery at a rate of up to 275% of applicable Medicare rates.

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

Rule 0800-02-17-.10 Payment, paragraph (2) is amended by changing the URL address in the second sentence to "www.cms.hhs.gov/home/medicare.asp", so that the new rule will read as follows:

(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/home/medicare.asp. Whenever a different guideline or procedure is not set forth in these Rules, the most current effective Medicare guidelines and procedures shall be followed.

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

Rule 0800-02-17-.10 Payment, paragraph (8) is amended by adding parentheses around "31" in the second sentence, so that the new rule will read as follows:

(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.

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

Rule 0800-02-17-.10 Payment, paragraph (12) is amended by deleting the phrase "or another medical insurance program" after the word "employee", so that the new rule will read as follows:

(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, 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).

Rule 0800-02-17-.13 Penalties for Violations of Fee Schedule Rules, paragraph (1) is amended by adding the words "up to" before the words "ten thousand dollars" in the second sentence, so that the new rule will read as follows:

(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 up to 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.

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).

Rule 0800-02-17-.14 Missed Appointment is amended by adding the sentence "The carrier shall make payment to the provider for the missed appointment pursuant to these Rules." between the current second and third sentences, so that the new rule will read as follows:

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. The carrier shall make payment to the provider for the missed appointment pursuant to these Rules. This amount shall not include any bill for diagnostic testing that would have been billed.

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

Rule 0800-02-17-.19 Preauthorization, paragraph (2) is amended by adding the phrase "the Division and" after the words "approved by" and by deleting the word "Division" after the words "prescribed in", so that the new rule will read as follows:

(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 Division and the Tennessee Department of Commerce and Insurance, as prescribed in 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).

Rule 0800-02-17-.20 Utilization Review, paragraph (2), subparagraphs (b)-(d) are amended by deleting the present language in its entirety and replacing it with the following:

(b) Utilization review shall be performed when mandated by and in accordance with Chapter 0800-02-06.

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).

Rule 0800-02-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills, paragraph (3), subparagraph (c) is amended by deleting the word "Medical" before "MCCCC", so that the new rules will read as follows:

(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 MCCCC.

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

Rule 0800-02-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills, paragraph (4), subparagraph (a) is amended by deleting the words "710 James Robertson Parkway, Andrew Johnson Tower, 2nd Floor" in the second sentence and replacing it with "220 French Landing Drive", so that the new rules will read as follows:

(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, 220 French Landing Drive, Nashville, Tennessee 37243.

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

Rule 0800-02-17-.25 Impairment Ratings-Evaluations and in Medical Records is amended by deleting the present language in its entirety and replacing it with the following:

(1) This rule applies to treating physicians. This rule is not applicable to independent medical examinations ("IME") or impairment ratings rendered as a part of an IME pursuant to Rule 0800-02-17-.09. As used in this Rule 0800-02-17-.25 only, a treating physician is that physician, chiropractor or medical practitioner who determines the employee has reached maximum medical improvement regarding the condition or injury for which the physician has provided treatment. A treating physician may include any of the following:

(a) a physician chosen from the panel required by T.C.A. Section 50-6-204;

(b) a physician referred to by the physician chosen from the panel required by T.C.A. Section 50-6-204;

(c) a physician recognized and authorized by the employer to treat an injured employee for a work-related injury; or

(d) a physician designated by the Division to treat an injured employee for a work-related injury.

(2) A treating physician is required and responsible for determining the employee's maximum medical improvement date and providing the employee's impairment rating for the injury the physician is treating. In some circumstances, a work-related accident may lead to multiple injuries that require multiple treating physicians. In such cases, the physician that is treating a distinct injury shall determine that the employee has reached maximum medical improvement as to that injury only and is required and responsible for providing an impairment rating for that injury only. A treating physician shall not be required or responsible for providing an impairment rating for an injury that the physician is not treating. The treating physician shall only be required to provide an impairment rating when the physician believes in good faith that the employee retains a permanent impairment upon reaching maximum medical improvement. If, after completion of the rating, it is determined that the employee has an impairment rating of zero, then the provisions of Rule 0800-02-17-.25(6) shall still apply. If the treating physician does not have a good faith belief that the employee retains a permanent impairment upon reaching maximum medical improvement, then the treating physician shall not be required to provide an impairment rating and shall not charge a fee for an impairment rating.

(3) All impairment ratings shall be made pursuant to T.C.A. Section 50-6-204(d)(3)(A).

(4) Within twenty-one (21) calendar days of the date the treating physician determines the employee has reached maximum medical improvement, the treating physician shall submit to the employer or carrier, as applicable, a fully completed report on a form prescribed by the Commissioner. The employer or carrier, as applicable, shall submit a fully completed form to the Division and the parties within thirty (30) calendar days of the date the treating physician determines the employee has reached maximum medical improvement.

(5) Upon determination of the employee's impairment rating, the treating physician shall enter the employee's impairment rating into the employee's medical records. In a response to a request for medical records pursuant to T.C.A. Section 50-6-204, a provider, treating physician or hospital shall include the portion of the medical records that includes the impairment rating.

(6) The treating physician is required and responsible for providing the impairment rating, fully completing the report on a form prescribed by the Commissioner, and submitting the report to the employer or carrier, as applicable, as required by these Rules. Notwithstanding Rule 0800-02-17-.15, the treating physician shall receive payment of no more than $250.00 for these services to be paid by the employer or carrier. The payment shall only be made to the treating physician. The treating physician shall not require prepayment of such fee.

(7) Failure to fully complete the form and submit it within the appropriate timeframes shall subject the employer, carrier or treating physician, as applicable, to a civil penalty of $100 for every fifteen (15) calendar days past the required date until the fully completed form is received by the Division.

Authority: T.C.A. §§ 50-6-204, 50-6-233 and 50-6-246.

Rule Amendments

0800-02-18
Medical Fee Schedule

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Rule 0800-02-18-.02 General Information and Instructions for Use, paragraph (2), subparagraph (b), part 4 is amended by adding the words "up to" before the words "$10,000.00" in the second sentence, so that the new rule will read as follows:

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 up to $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").

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

Rule 0800-02-18-.02 General Information and Instructions for Use, paragraph (4), subparagraphs (a) and (b) are amended by deleting the current language in its entirety and replacing it with the following:

(4) (a) Monetary Conversion Factors are based on the CMS' unit amount in effect on March 4, 2008. These Factors are subject to change based upon any change in the Medicare unit amount. If the Medicare Conversion Factor falls below the unit amount in effect on March 4, 2008, the Department will adjust the Tennessee Medical Fee Schedule Conversion Factors listed on the Division's website to maintain the equivalent maximum allowable reimbursement which would have been allowed had the Medicare Conversion Factor remained at the amount in effect on March 4, 2008. In no event shall reimbursement amounts under this Chapter be less than the amounts applicable on March 4, 2008.

(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. Board-eligible and certified neurosurgeons and orthopedic surgeons shall use the separate neurosurgery and orthopedic surgery conversion factors listed on the Division's website for all surgery CPT codes.

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

Rule 0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), paragraph (1), subparagraph (h), parts 2 and 3 are amended by deleting the current language in its entirety and replacing it with the following:

2. Laboratory services (including pathology, which is reimbursed at the usual and customary amount regardless of where performed)

3. Radiology services (professional and/or technical components may only be separately reimbursed when not included in APC)

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

Rule 0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), paragraph (1), subparagraph (k) is amended by deleting the space between "out" and "patient" in the first sentence so that the new rule will read as follows:

(k) There may be occasions in which the patient was scheduled for outpatient 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.

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

Rule 0800-02-18-.08 Chiropractic Services Guidelines, paragraph (1) is amended by deleting the phrase ", except that the thirty (30) calendar day time period therein shall not apply to chiropractic services" at the end of the third sentence, so that the new rule will read as follows:

(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.

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

Rule 0800-02-18-.09 Physical and Occupational Therapy Guidelines, paragraph (5) is amended by deleting the current language in its entirety and replacing it with the following:

(5) Whenever physical therapy and/or occupational therapy services exceed six (6) visits, or in cases which are post-operative, twelve (12) visits, such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in Chapter 0800-02-06 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within the timeframes set forth in Chapter 0800-02-06 to assure no interruption in delivery of needed services. Failure by a provider to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. Failure by an employer or utilization review agent to conduct utilization review in accordance with this Chapter 0800-02-18 and Chapter 0800-02-06 shall result in no more than twelve (12) additional visits being deemed certified. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of visits. If 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).

Rule 0800-02-18-.10 Durable Medical Equipment and Implant Guidelines, paragraph (1) is amended by deleting the phrase "eighty-five (85%)" in the first sentence and replacing it with "eighty (80%)", so that the new rule will read as follows:

(1) Reimbursement for durable medical equipment and implants for which billed charges are $100.00 or less shall be limited to eighty (80%) 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.

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

Rule 0800-02-18-.10 Durable Medical Equipment and Implant Guidelines is amended by adding a new paragraph (2) at the end of the rule, which will read as follows:

(2) This Rule 0800-02-18-.10 shall not apply to durable medical equipment and medical supplies (other than implants) with applicable Medicare allowable amounts. Such durable medical equipment and medical supplies (other than implants) shall be reimbursed at the lesser of the billed charges or 100% of the applicable Medicare allowable amount.

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

Rule 0800-02-18-.11 Orthotics and Prosthetics Guidelines is amended by deleting the phrase "1650 King Street, Suite 500, Alexandria, VA 22314, (703) 836-7116" in the second sentence and replacing it with "330 John Carlyle Street, Suite 200, Alexandria, VA 22314, (571) 431-0876", so that the new rule will read as follows:

(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, 330 John Carlyle Street, Suite 200, Alexandria, VA 22314, (571) 431-0876. Orthotics and prosthetics shall be reimbursed up to a maximum of 115% of the Tennessee Medicare allowable amount and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from, all 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).

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, paragraph (1), subparagraph (e), part 2 is amended by deleting the word "charge" after the word "usual" in the second sentence, so that the new rule will read as follows:

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 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.

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

Rule 0800-02-18-.15 Penalties for Violations of Fee Schedules, paragraph (1) is amended by adding the words "up to" before the words "ten thousand dollars" in the second sentence, so that the new rule will read as follows:

(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 up to 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.

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

Rule Amendments

0800-02-19
In-Patient Hospital Fee Schedule

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Rule 0800-02-19-.02 Definitions, paragraph (16) is amended by deleting "eighty-five percent (85%)" and replacing it with "eighty percent (80%)", so that the new rule will read as follows:

(16) "Usual and customary charge" means eighty percent (80%) of a specific provider's average charges to all payers for the same procedure.

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

Rule 0800-02-19-.03 Special Ground Rules – Inpatient Hospital Services, paragraph (2), subparagraph (d), part 3 is amended by deleting "eighty-five percent (85%)" in the second sentence and replacing it with "eighty percent (80%)", so that the new rule will read as follows:

3. Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). Maximum reimbursement for implantables for which charges are $100.00 or less per item shall be limited to eighty percent (80%) of billed charges. Maximum reimbursement for implantables for which charges are over $100.00 is limited to a maximum of the hospital's cost plus fifteen percent (15%) of the invoice amount, up to a maximum of invoice plus $1,000.00. This is applicable per item, and is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables which have an invoice amount over $100.00 shall be accompanied by an invoice if requested by the payer.

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

Rule 0800-02-19-.04 Pre-admission Utilization Review is amended by deleting the current language in its entirety and replacing it with the following:

Utilization review shall be performed when mandated by and in accordance with Chapter 0800-02-06.

Authority: T.C.A. §§ 50-6-124, 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

Rule 0800-02-19-.05 Other Services, paragraph (2), subparagraph (a) is amended by adding the words "and technical" after the word "professional", so that the new rule will read as follows:

(a) All non-institutional professional and technical services will be reimbursed in accordance with the Division's Medical Cost Containment Program Rules and Medical Fee Schedule Rules which must be used in conjunction with these Rules.

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

Rule 0800-02-19-.06 Penalties for Violations of Fee Schedules, paragraph (1) is amended by adding the words "up to" before the words "ten thousand dollars" in the second sentence, so that the new rule will read as follows:

(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 up to 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 alleged 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.

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

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Department of Labor and Workforce Development (board/commission/ other authority) on 4/14/09 (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 01/30/2009

Notice published in the Tennessee Administrative Register on: 02/13/2009

Rulemaking Hearing(s) Conducted on: (add more dates). 03/20/2009

Date: April 14, 09

Signature: James G. Neeley

Name of Officer: James G. Neeley

Title of Officer: Commissioner of Labor and Workforce Development

Vicki [illegible] Gregory
State of Tennessee Notary Public
Cheatham County

Subscribed and sworn to before me on: April 14, 2009

Notary Public Signature: Vicki A Gregory

My commission expires on: December 31, 2012

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

R E Cooper Jr

Robert E. Cooper, Jr.
Attorney General and Reporter

6-10-09
Date

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PUBLICATIONS

Filed with the Department of State on: 6/12/09

Effective on: 8/26/09

Tre Hargett

Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. §4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Comment: Rule 0800-02-17-.25(6) should be revised so that "reimbursement" or "payment" to the treating physician shall be no more than $250, rather than the "charge" shall be no more than $250. Medical bills are rarely paid at 100% of charges, so this revision would allow the treating physician to actually be reimbursed at $250. In addition, the fee schedule emphasizes reimbursement levels (i.e., what was actually paid), not bills. For the same reasons, Rule 0800-02-17-.03(42) should be revised to replace "bills" with "reimbursements."

Response: The Department agrees and revised Rule 0800-02-17-.25(6). The Department also agrees that the language in Rule 0800-02-17-.03(42) should be changed to "reimbursements." Unfortunately, the rulemaking notice only added the words "up to" to that rule, so that a change from "bills" to "reimbursements" would not come within the rulemaking notice. The Department intends to make that change during the next review of the rules.

Comment: Rule 0800-02-17-.25(2) needs to be clarified so that a treating physician who has a good faith belief that an injured employee retains a permanent impairment upon reaching maximum medical improvement can still be reimbursed for providing the rating even if the result is a 0% rating.

Response: The Department agrees and revised the rules.

Comment: Rule 0800-02-18-.10 should be revised to increase the reimbursement rate for durable medical equipment to 125% of the Medicare allowable amount because durable medical equipment companies have difficulty making a profit under the current reimbursement levels. In addition, whether the rates stay the same or not, the rule should be clarified by including language to the effect of "reimbursement shall be the lesser of the usual and customary charge or the Medicare allowable amount" so that the proper reimbursement rate is more apparent. The Department should also consider exemptions to the fee schedule for supply companies and/or for certain services that cost more than the fee schedule allows.

Response: While 125% of the Medicare allowable amount would add too much cost, the Department did revise the rule so that durable medical equipment can be reimbursed at a rate of up to 100% of Medicare when there is an applicable Medicare amount. The Department also added the suggested clarifying language regarding the usual and customary charge comparison, but used "billed charge" to be more consistent with the other provisions of the chapter. The Department cannot exempt any companies or services from the fee schedule, but allowing reimbursement at up to 100% of the Medicare allowable amount should ameliorate situations where the current fee schedule is inadequate.

Regulatory Flexibility Addendum
Pursuant to Public Chapter 464 of the 105th General Assembly, prior to initiating the rule making process as described in § 4-5-202(a)(3) and § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The amended rules will benefit anyone who is attempting to comply with the rules because of the corrections and updates. The amended rules update reimbursement rates and allow the Department to adjust rates on the Department's website when there is a change in Medicare rates. As for the impairment rating rule in 0800-02-17-.25, employers and insurance carriers will benefit by receiving the impairment rating from the treating physician sooner than under the current rule. Health care providers that choose to treat injured employees will be required to provide an impairment rating and may charge a fee of up to $250 for this service.

2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record: As is already the case, businesses will need to be familiar with health care coding and billing, but these amended rules do not increase that existing cost. As for the impairment rating rule, health care providers who choose to treat injured employees will need to be familiar with the AMA Guides in order to provide the impairment rating.

3. A statement of the probable effect on impacted small businesses and consumers: The corrections and updates will benefit anyone who is attempting to comply with the rules. In addition, employers and employees will have quicker access to impairment ratings than under the current rule. As such, the amended rule will allow the parties to settle the compensation claim sooner, which should save legal and administrative costs. Health care providers who choose to treat injured employees will be required to provide the impairment rating within twenty-one (21) days, but will also be able to charge a fee for this service.

4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of the amended rules.

5. Comparison of the proposed rule with any federal or state counterparts: No other similar rules exist in this state or on the federal level.

6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: Any exemption would slow the process by which an injured employee's impairment rating is determined and would thwart the purposes and objectives of the amended rules.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to TCA 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The amended rules correct several typos and outdated information. The amended rules also codify the changes to the Impairment Rating Rule in 0800-02-17-.25, which is currently in temporary form as a public necessity rule. The amended rules update reimbursement rates and allow the Department to adjust rates on the Department's website when there is a change in Medicare rates.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Tenn. Code Ann. § 50-6-204(i) requires the Commissioner to enact a comprehensive medical fee schedule for workers' compensation claims. These amended rules merely update the rules that are already in place. Tenn. Code Ann. § 50-6-246 required the Commissioner to promulgate an impairment rating rule, and these amended rules will codify the Impairment Rating Rule, 0800-02-17-.25, in permanent form.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

The amended rules correct and update several sections, which will help anyone who is attempting to comply with the rules. As for the impairment rating rule, employers and their insurance carriers urge adoption of the amended rule because it will allow them to receive the impairment rating sooner and make an informed settlement offer to the injured employee. Likewise, injured employees and their attorneys will be able to settle cases and receive compensation sooner. Physician groups have also supported the reimbursement of $250 in the impairment rating rule and have supported the utilization of the Division's website to update rates when there is a change in Medicare rates.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

There have been no Attorney General opinions or judicial rulings relevant to these rules.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

There are no anticipated increases or decreases in state and local government revenues and expenditures resulting from promulgation of the amended rules.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Landon Lackey, attorney with the Division of Workers' Compensation, may be contacted for more information.

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Landon Lackey will explain the rules at a scheduled meeting of the committees.

(H) Office address and telephone number of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

220 French Landing Drive

Nashville, Tennessee 37243 615-532-0370

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

None