Department of State
Division of Publications
312 Rosa L. Parks, 8th Floor Snodgrass/TN Tower
Nashville, TN 37243
Phone: 615.741.2650
Email: publications.information@tn.gov

For Department of State Use Only
Sequence Number: 06-16-19
Rule ID(s): 9037
File Date: 06/12/19
Effective Date: 09/10/19

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Drive 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

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

Rule(s) (**ALL** chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	**Chapter Title**
0800-02-19	Inpatient Hospital Fee Schedule
Rule Number	**Rule Title**
0800-02-19-.01	General Rules
0800-02-19-.02	Definitions
0800-02-19-.03	Special Ground Rules – Inpatient Hospital Services
0800-02-19-.04	Pre-admission Utilization Review
0800-02-19-.05	Other Services
0800-02-19-.06	Penalties for Violations of Fee Schedules

In-Patient Hospital Fee Schedule
Amended Rules
Rule 0800-02-19

0800-02-19-.01 General Rules is amended by deleting subparagraph (2)(b) and substituting instead the following language so that, as amended, subparagraph (2)(b) shall read:

(2) General Information

(b) The most recent Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and shall be effective upon adoption and implementation by the CMS. All such Medicare procedures and guidelines are applicable unless these Rules set forth a different procedure or guideline. Whenever there is no specific maximum fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the Medicare allowable amount and the Medicare guidelines and procedures effective on the date of service shall be followed in arriving at the correct amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed up to a maximum of the usual and customary amount, as defined in Rule 0800-02-17-.03. All Medicare rules shall be applied that are effective on the date of service or the date of discharge in accordance with Medicare guidelines.

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

0800-02-19-.02 Definitions is amended by deleting paragraphs (4), (10) and (11) and replacing those paragraphs with the following language:

(4) "MS-DRG" – Medicare classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns.

(10) "Stop-Loss Payment" ("SLP") - an independent method of payment for an inpatient hospital stay. This provision does not apply to skilled nursing facilities.

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

Authority: T.C.A. §§ 50-6-102, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Repl. 2005), 50-6-233, and Public Chapters 282 & 289 (2013).

0800-02-19-.03 Special Ground Rules – Inpatient Hospital Services is amended by deleting the rule and substituting instead the following language so that, as amended, the rule shall read:

0800-02-19-.03 Special Ground Rules – Inpatient Hospital Services.

(1) This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals. Hospital reimbursement is divided into four (4) groups based on type of admission:

(a) Peer Groups:

1. Peer Group 1-surgical or non-surgical (medical);

2. Peer Group 2-rehabilitation;

3. Peer Group 3-psychiatric;

4. Peer Group 4-trauma, level 1 and:

(b) Length of stay (less than eight (8) days/over seven (7) days).

(2) General Information, Payments

For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (MS- DRG) code which appropriately reflects the patient's primary cause for hospitalization to determine average length of stay and for tracking purposes. Hospitals within each peer group are to be paid the maximum amount per inpatient day unless a contracted rate is less. An additional payment will be due if the total bill for the hospitalization exceeds the stop loss threshold as defined below.

(a) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:

1.	Peer Group 1	$2,347.00 (surgical admission) daily for the first seven (7) days; $2,032.00 (surgical admission) per day for the 8th day and thereafter; Note: these rates include Intensive Care (ICU) & Critical and Cardiac Care (CCU) if not a trauma admission as defined above. $1,932.00 (medical admission) daily for first seven (7) days; $1,670.00 (medical admission) per day for the 8th day and thereafter; Note: these rates include Intensive Care (ICU) & Critical and Cardiac Care (CCU)
2.	Peer Group 2 (Rehabilitation)	$1,145.00 for the first seven (7) days and $935.00 per day thereafter;
3.	Peer Group 3 (Psychiatric)	$830.00 per day (applicable also to chemical dependency);

4.	Peer Group 4 (Trauma level 1)	All trauma care at any licensed Level 1 Trauma Center only shall be reimbursed at a maximum rate of $4,725.00 per day for each day of the patient's admission as defined in 0800-02-18-.02(16).

(b) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.

(c) Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges. Non-covered charges are convenience items or charges for services not related to the work injury/illness.

(d) Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). Reimbursement for implantables is limited to a maximum of the hospital's cost plus fifteen percent (15%)-capped at one thousand dollars ($1000.00)-of the invoice amount. This is applicable per item, and is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables shall be accompanied by an invoice to the payer.

(e) The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All of these items must be listed with the applicable CPT®/HCPCS.

1. Durable Medical Equipment;
2. Orthotics and Prosthetics;
3. Implantables;
4. Ambulance Services;
5. Take home medications and supplies.

(f) The items listed in subsection (e) shall be reimbursed according to the Rules for Medical Payments (Chapter 0800-02-17, and the Medical Fee Schedule Rules (Chapter 0800-02-18) payment limits. Refer to the maximum rates set forth in Rule 0800-02-18 for practitioner fees. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-02-17, unless otherwise indicated herein.

(g) Per- diem rates are all inclusive (with the exception of those items listed in subsection (e) above).

(h) The In-patient Hospital Fee Schedule allows for independent reimbursement on a case- by-case basis if the particular care exceeds the Stop-Loss Threshold.

(i) Payments for implantables shall be made only to the facility and not to a supplier or distributor.

(j) Charges for licensed/accredited Skilled Nursing Facilities shall be paid according to the CMS national unadjusted rates for urban or rural facilities in effect on the date of service, applicable carve outs, including adjustments made under "Patient-Drive Payment Model" (PDPM) or later CMS methodology. The bill shall include the applicable "Resource Utilization Group" (RUG) for each day. Hospital per-diem and stop loss calculations do not apply to these facilities.

(3) Reimbursement Calculations

(a) Explanation

1. Each admission is assigned an appropriate MS-DRG.

2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission plus items listed under (e) above:

   Formula: (LOS) X (SPDA) + (items listed under (e) above) = WCRA

3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission and may include a stop loss payment ("SLP") as calculated below.

(4) Stop-Loss Method

(a) Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for services rendered during treatment to an injured worker. This stop-loss threshold is established to ensure compensation for services required during an admission.

(b) Explanation

1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least $21,788.00 for Non-Trauma Admissions and $31,500.00 for Trauma Admissions. This does not include amounts for items set forth in rule 0800-02-19-.03, such as implantables, DME, etc., which shall not be included in determining the total Allowed Charges for stop-loss calculations.

2. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.

3. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(c) Formula: (LOS) x (SPDA) + (Items listed under (2)(e) in this section) + (Additional Charges x SLRF) = WCRA

(5) Billing for In-patient Admissions

(a) All bills for in-patient institutional services shall be submitted on the standard billing form or any revision to that form approved for use by the Medicare.

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

* If a roll-call vote was necessary, the vote by the Agency on these 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 Tennessee Bureau of Workers' Compensation on 4/18/19 and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on November 21, 2018.

Rulemaking Hearing Conducted on January 17, 2019.

JANIE L. DORRIS
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
MY COMMISSION EXPIRES 3-8-2022

Date: April 18, 2019

Signature: Abbie Hudgens

Name of Officer: Abbie Hudgens

Title of Officer: Administrator, Bureau of Workers' Compensation

Subscribed and sworn to before me on: 4/18/19

Notary Public Signature: Janie L Dorris

My commission expires on: 3/8/22

Agency/Board/Commission: Department of Labor & Workforce Development
Bureau of Workers' Compensation

Rule Chapter Number(s): 0800-02-19

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.

Herbert H. Slatery III

Herbert H. Slatery III
Attorney General and Reporter

6/7/2019
Date

Department of State Use Only

RECEIVED
2019 JUN 12 AM 11:34
SECRETARY OF STATE
RULES FILING DESK

Filed with the Department of State on: 06/12/19

Effective on: 09/10/19

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.

PUBLIC COMMENTS AND RESPONSES

Comment:
Michael Haynie at Manier Herod law firm: References to the Tennessee workers' compensation act should be changed to the Tennessee workers' compensation law to be consistent with word usage in Title 50.
Response: The bureau agrees and has made the suggested changes.
Comment:
Neil Aronov, PhD:
1) Payments to psychologists should be increased to be consistent with increases in medical fee schedule for other medical providers.
Response: The bureau agrees. The increases to psychologists were included in the medical fee schedule increases included in these rules.
2) Psychologists should be permitted to declare a patient at maximum medical improvement and provide a permanent impairment rating.
Response: The bureau neither agrees nor disagrees; this is beyond the scope of the medical fee schedule rules. A statutory change would be needed to permit a psychologist to perform functions that are presently done by physicians pursuant to statute.
Comment:
Tennessee Hospital Association
1) THA supports the fee schedule changes in 0800-02-18 that would base physician reimbursement on the Medicare physician fee schedule conversion factor in effect on the date of service, as opposed to the current fixed conversion factor in the current rule that is consistent with the 2011 Medicare conversion factor.
Response: The bureau agrees.
2) Inpatient hospital fee schedule increase should be changed to 6.07% instead of the proposed 5% to be consistent with 2019 conversion factor change.
Response: The bureau defers at this time. The current changes being made to the medical fee schedule rules were based upon a 2018 review. Making this suggested change would require re-pricing the entire medical fee schedule. However, the bureau has already agreed to review the inpatient fee schedule for its 2019 annual review required by statute, including the stop loss and per diem payment methodologies.
Comment:
Tennessee Radiologists Society (TRS) and Tennessee Radiology Business Managers Association (RBMA):
1) We support the proposed change to float the Medicare conversion factor with the current Medicare conversion factor rather than freezing the number in rule.
Response: The bureau agrees.
2) We suggest adding the phrase "free-standing outpatient diagnostic center" to Rule 0800-02-18-.07(c) to clarify the application of the OPPS rate to the technical services component of radiology services.
Response: The bureau disagrees at this time. This rule only applies to ASCs. To include free-standing outpatient diagnostic centers was not the intent of this section of the rule. The category of diagnostic centers will be subject to review as a part of the statutorily required annual review of the medical fee schedule in 2019.
Comment:
Coventry
1) In 0800-02-17-.09(4) there is a statement: "The reimbursement shall be $200.00 for the first hour of review and $100.00 for each additional hour, provided that each half hour shall be pro-rated." Should this sentence change to clarify the applicability if a prepayment request may not exceed $200?
Response: The bureau disagrees that a clarification needs to be made. This methodology is consistent with other bureau rules regarding medical depositions.
2) In 0800-02-17-.22(1)(a), suggestion is made to add the following: "Submissions that are received less than one week before a Committee meeting will be held and reviewed at the next regularly scheduled meeting."
Response: The bureau agrees with the comment, and the issue of late submissions has been addressed in 0800-02-17-.22(1)(b). Note that this applies only to "written submissions" that are received less than one week prior to the meeting and does not limit oral discussion.
Comment:

John Williams-TAPA: In 0800-02-18.04(2)(c) this change is being made: "PA and APN fees will be based on the specialty of their collaborating physician for all services except those defined as 'assistants at surgery'." How will this impact the payments to PAs and APNs?
Response: The proposed change created confusion about the specialty collaborating physician designation as noted above. APN and PA reimbursement will be calculated according to Medicare billing rules at 160% using a fixed Tennessee specific conversion percentage. This will increase their payments to 85% of the current Medicare conversion factor multiplied by the 160%, providing for a simpler calculation, and will annually "float" with the Medicare conversion factor.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rulemaking process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects 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 affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or for those in the construction industry at least one employee. There should be no additional costs associated with these rule changes.

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. There is no additional record keeping requirement or administrative cost associated with these rule changes.

3. A statement of the probable effect on impacted small businesses and consumers: These rules should not have any impact on consumers or small businesses.

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 these rules.

5. Comparison of the proposed rule with any federal or state counterparts: None.

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: Exempting small businesses could frustrate the small business owners' access to the services provided by the Bureau of Workers' Compensation and timely medical treatment for injured workers, which would be counter-productive.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

These proposed rules will have little, if any, impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 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;

These rules together with the Rules for Medical Payments and Medical Fee Schedule Rules establish a comprehensive medical fee schedule, procedures for review of bills and enforcement procedures.

(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;

T.C.A. § 50-6-204 provides that the Bureau administrator is authorized to establish by rule a comprehensive medical fee schedule and will review it annually and make revisions as necessary.

(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;

All parties to a workers' compensation claim will be affected by the adoption or rejection of these rules.

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

None

(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;

The overall effect will have little fiscal impact upon state or local government.

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

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

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

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

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

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, Floor 1-B
Nashville, TN 37243
(615) 532-0179
troy.haley@tn.gov

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

None

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

CHAPTER 0800-02-19
IN-PATIENT HOSPITAL FEE SCHEDULE

TABLE OF CONTENTS

0800-02-19-.01	General Rules	0800-02-19-.04	Pre-admission Utilization Review
0800-02-19-.02	Definitions	0800-02-19-.05	Other Services
0800-02-19-.03	Special Ground Rules – Inpatient Hospital Services	0800-02-19-.06	Penalties for Violations of Fee Schedules

0800-02-19-.01 GENERAL RULES.

(1) These In-patient Hospital Fee Schedule Rules are applicable to all in-patient services as defined herein. These include medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured or ill workers claiming medical benefits pursuant to the Tennessee Workers' Compensation Act. Maximum fees for outpatient hospital services are not addressed in these In-patient Hospital Fee Schedule Rules, but are addressed in Rule 0800-02-18-.07 of the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq. These In-patient Hospital Fee Schedule Rules are established pursuant to Tenn. Code Ann. § 50-6-204. They must be used in conjunction with the Rules for Medical Payments, Chapter 0800-02-17-.01 et seq., and the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq., as the definitions and provisions set forth in those rules are incorporated as if set forth fully herein. Providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers' Compensation Act may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided, if a waiver is granted by the Bureau.

(2) General Information

(a) Reimbursements shall be determined for services rendered in accordance with these Fee Schedule Rules and shall be considered to be inclusive unless otherwise expressly noted in these Rules.

(b) The most recent Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and shall be effective upon adoption and implementation by the CMS. All such Medicare procedures and guidelines are applicable unless these Rules set forth a different procedure or guideline. Whenever there is no specific maximum 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 recent and effective~~ Medicare allowable amount and the ~~most recent effective~~ Medicare guidelines and procedures effective on the date of service shall be followed in arriving at the correct amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed up to a maximum of the usual and customary amount, as defined in Rule 0800-02-17-.03. All Medicare rules shall be applied that are effective on the date of service or the date of discharge in accordance with Medicare guidelines.

(c) Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges or the maximum amount allowed under this In-patient Hospital Fee Schedule.

(d) In-patient hospitals shall be grouped into the following separate peer groupings:

(Rule 0800-02-19-.01, continued)

1. Peer Group 1 Hospitals;
2. Peer Group 2 Rehabilitation Hospitals;
3. Peer Group 3 Psychiatric Hospitals;
4. Peer Group 4 Designated Level 1 Trauma Centers.

(e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("MS-DRG") code which appropriately reflects the patient's primary cause of hospitalization.

(f) Prospective utilization review is required for non-emergent, non-urgent inpatient services. Emergency or urgent admissions require utilization review to begin within one (1) business day of the employer receiving notification of the admission.

Authority: *T.C.A. §§ 50-6-124, 50-6-125, 50-6-128, 50-6-204, and 50-6-205 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendments filed November 27, 2017; effective February 25, 2018.*

0800-02-19-.02 DEFINITIONS.

(1) "Administrator" means the chief administrative officer of the Bureau of Workers' Compensation or the Administrator's designee.

(2) "Allowed Charges" or "Allowable Charges" shall mean charges as prescribed in the Bureau's Rules, or as determined by the Administrator or the Administrator's designee after consultation with the Bureau's Medical Director.

(3) "Bureau" means the Tennessee Bureau of Workers' Compensation.

(4) "MS-DRG" – Medicare classifications of diagnoseis in which patients demonstrate similar resource consumption and length of stay patterns.

(5) "Hospital" is the same as the definition for Medicare.

(6) "In-patient Services" - services rendered to a person who is formally admitted to a hospital and whose length of stay as defined by Medicare:

(a) Is expected to include at least two midnights, or;

(b) The medical record supports the admitting physician's determination that the patient requires inpatient care despite the lack of a two midnight length of stay, or;

(c) The procedure/treatment is included on the "in-patient only" list.

(7) "Institutional Services" - all non-physician services rendered within the institution by an agent of the institution.

(8) "Length of Stay" ("LOS") - number of days of admission where patient appears on midnight census. Last day of stay shall count as an admission day if it is medically necessary for the patient to remain in the hospital beyond 12:00 noon as defined by Medicare.

(Rule 0800-02-19-.02, continued)

(9) "Medical Admission" - any hospital admission where the primary services rendered are not surgical, or in a psychiatric, or rehabilitation hospital, or in a specially designated psychiatric or rehabilitation unit within an acute care hospital.

(10) "Stop-Loss Payment" ("SLP") - an independent method of payment for an inpatient hospital ~~unusually costly or lengthy~~ stay. This provision does not apply to skilled nursing facilities.

(11) "Stop-Loss Reimbursement Factor" ("SLRF") - a factor established by the Bureau~~Division~~ to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.

(12) "Stop-Loss Threshold" ("SLT") - threshold of total charges established by the Bureau, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor times the total charges identifying that particular threshold.

(13) "Surgical Admission" - any hospital admission where the patient has an assigned surgical MS-DRG as defined by the Medicare.

(14) "Transfers between Facilities" - to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. This may or may not involve a change in the admittance status of the patient, i.e. patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in facility in which patient has been admitted. This includes costs related to transportation of patient to obtain medical care.

(15) "Trauma Admission" – means:

(a) Any level 1 trauma center hospital admission in which the patient has an ICD-9 diagnosis code of 800 to 959.99, or ICD-10 code that is (or includes) S00.00XA through S99.99XX, T07, T14 to T32, T79 and the claim includes an ICU revenue code of 020x or a CCU revenue code of 021x, or

(b) Any level 1 trauma center hospital admission for any diagnosis with a trauma response revenue code of 068x and/or type of admission code, "5."

Note: this includes all hospital days that qualify as an inpatient day as defined under inpatient services.

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

(17) "Utilization Review" for workers' compensation claims means evaluation of the necessity, appropriateness, efficiency and quality of medical care services provided to an injured or disabled employee based on medically accepted standards and an objective evaluation of the medical care services provided; provided, that "utilization review" does not include the establishment of approved payment levels or a review of medical charges or fees.

(18) "Workers' Compensation Standard Per Diem Amount" ("SPDA") - A standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: *T.C.A. §§ 50-6-102, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Repl. 2005), 50-6-233, and Public Chapters 282 & 289 (2013).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014. Amendments filed November 27, 2017; effective February 25, 2018.*

0800-02-19-.03 SPECIAL GROUND RULES – INPATIENT HOSPITAL SERVICES.

(1) This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals. Hospital reimbursement is divided into four (4) groups based on type of admission:

(a) Peer Groups:

1. Peer Group 1-surgical or non-surgical(medical);

2. Peer Group 2-rehabilitation;

3. Peer Group 3-psychiatric;

4. Peer Group 4-trauma, level 1 and:

(b) Length of stay (less than eight (8) days/over seven (7) days).

(2) General Information, Payments

For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (MS-DRG) code which appropriately reflects the patient's primary cause for hospitalization to determine average length of stay and for tracking purposes. Hospitals within each peer group are to be paid the maximum amount per inpatient day unless a contracted rate is less. An additional payment will be due if the total bill for the hospitalization exceeds the stop loss threshold as defined below.

(a) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:

1. Peer Group 1	$2,347.00 ~~2,235.00~~ (surgical admission) daily for the first seven (7) days;
	$2,032.00 ~~1,935.00~~ (surgical admission) per day for the 8th day and thereafter;
	Note: these rates include Intensive Care (ICU) & Critical and Cardiac Care (CCU) if not a trauma admission as defined above.
	$1,932.00 ~~1,840.00~~ (medical admission) daily for first seven (7) days;
	$1,670.00 ~~1,590.00~~ (medical admission) per day for the 8th day and thereafter;
	Note: these rates include Intensive Care (ICU) & Critical and Cardiac Care (CCU)
2. Peer Group 2 (Rehabilitation)	$1,145.00 ~~1,090.00~~ for the first seven (7) days and $935.00 ~~890.00~~ per day thereafter;
3. Peer Group 3 (Psychiatric)	$830.00 ~~790.00~~ per day (applicable also to chemical dependency);

4.	Peer Group 4 (Trauma level 1)	All trauma care at any licensed Level 1 Trauma Center only shall be reimbursed at a maximum rate of $4,725.00 ~~4,500.00~~ per day for each day of the patient's admission as defined in 0800-02-18-

(b) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.

(c) Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges. Non-covered charges are convenience items or charges for services not related to the work injury/illness.

(d) Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). Reimbursement for implantables is limited to a maximum of the hospital's cost plus fifteen percent (15%)-capped at one thousand dollars ($1000.00)-of the invoice amount. This is applicable per item, and is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables shall be accompanied by an invoice ~~if requested by~~ to the payer.

(e) The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All of these items must be listed with the applicable CPT®/HCPCS.

1. Durable Medical Equipment;
2. Orthotics and Prosthetics;
3. Implantables;
4. Ambulance Services;
5. Take home medications and supplies.

(f) The items listed in subsection (e) shall be reimbursed according to the Rules for Medical Payments (Chapter 0800-02-17, and the Medical Fee Schedule Rules (Chapter 0800-02-18) payment limits. Refer to the maximum rates set forth in Rule 0800-02-18 for practitioner fees. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-02-17, unless otherwise indicated herein.

(g) Per- diem rates are all inclusive (with the exception of those items listed in ~~-~~subsection (e) above).

(h) The In-patient Hospital Fee Schedule allows for independent reimbursement on a case-by-case basis if the particular care exceeds the Stop-Loss Threshold.

(i) Payments for implantables shall be made only to the facility and not to a supplier or distributor.

(j) Charges for licensed/accredited Skilled Nursing Facilities shall be paid according to the CMS national unadjusted rates for urban or rural facilities in effect on the date of service, applicable carve outs, including adjustments made under "Patient-Drive Payment Model" (PDPM) or later CMS methodology. The bill shall include the applicable "Resource Utilization Group" (RUG) for each day. Hospital per-diem and stop loss calculations do not apply to these facilities.

(Rule 0800-02-19-.03, continued)

(3) ReimbursementCalculations

(a) Explanation

1. Each admission is assigned an appropriate MS-DRG.

(Rule 0800-02-19-.03, continued)

2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission plus items listed under (e) above:

   Formula: (LOS) X (SPDA) + (items listed under (e) above) = WCRA

3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission and may include a stop loss payment ("SLP") as calculated below.

(4) Stop-Loss Method

(a) Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for ~~unusually costly~~ services rendered during treatment to an injured worker. This stop-loss threshold is established to ensure compensation for ~~for unusually extensive~~ services required during an admission.

(b) Explanation

1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least $21,788.00~~20,750~~ for Non-Trauma Admissions and $31,500.00~~30,000.00~~ for Trauma Admissions. This does not include amounts for items set forth in rule 0800-02-19-.03, such as implantables, DME, etc., which shall not be included in determining the total Allowed Charges for stop-loss calculations.

2. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.

3. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(c) Formula: (LOS) x (SPDA) + (Items listed under (2)(e) in this section) + (Additional Charges x SLRF) = WCRA

(5) Billing for In-patient Admissions

(a) All bills for in-patient institutional services shall be submitted on the standard billing form or any revision to that form approved for use by the Medicare.

Authority: *T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, and 50-6-205 (Repl. 2005).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendments filed March 12, 2012; to have been effective June 10, 2012. The Government Operations Committee filed a stay on May 7, 2012; new effective date August 9, 2012. Amendments filed November 27, 2017; effective February 25, 2018.*

0800-02-19-.04 PRE-ADMISSION UTILIZATION REVIEW.

Utilization review shall be performed 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).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February*

(Rule 0800-02-19-.04, continued)

3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendments filed November 27, 2017; effective February 25, 2018.

0800-02-19-.05 OTHER SERVICES.

(1) Pharmacy Services

(a) Pharmaceutical services rendered as part of in-patient care are considered inclusive within the In-patient Fee Schedule and shall not be reimbursed separately.

(b) All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines, Rule 0800-02-18-.12.

(2) Professional Services

(a) All non-institutional professional and technical services will be reimbursed in accordance with the Bureau's Rules for Medical Payments and the 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).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendments filed November 27, 2017; effective February 25, 2018.*

0800-02-19-.06 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

(1) Except when a waiver is granted by the Bureau, providers shall not accept and employers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Rules for Medical Payments, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer paying an amount in excess of the Rules shall be in violation of the Rules and may, at the Administrator's discretion, be subject to civil penalties of up to one thousand dollars ($1,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Other violations of the Rules for Medical Payments, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules may subject the alleged violator(s) to a civil penalty of not less than one hundred dollars ($100.00) nor more than one thousand dollars ($1,000.00) per violation, at the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator.

(2) Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of one hundred eighty (180) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules.

(3) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, the 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.

(4) The request for a hearing shall be made to the Bureau in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.

(5) Any request for a hearing shall be filed with the Bureau within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator becoming a final order and not subject to further review.

(6) The Administrator or the Administrator's Designee, shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed. All procedural aspects set forth in the Bureau's Penalty Rules, Chapter 0800-02-13, shall apply and be followed in any such contested case hearing.

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

Authority: *T.C.A. §§ 50-6-102, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013).* ***Administrative History:*** *Public necessity rule filed June 5, 2005; effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12, 2009; effective August 26, 2009. Amendment filed December 26, 2013; effective March 26, 2014. Amendments filed November 27, 2017; effective February 25, 2018.*

*NOTE: All references to the "Tennessee Workers' Compensation Act" or "Act" are being changed to "Tennessee Workers' Compensation Law" or "Law".