TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800
Division of Workers' Compensation

There will be a hearing before the Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, to consider the promulgation of amendments to rules pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-204, 50-6-204, 50-6-205 and 50-6-233. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Media Room, on the Third Floor of the W.R. Snodgrass (Tennessee) Tower, 312 8th Ave. North, Nashville, Tennessee 37243 at 1:00 p.m. CDST on the 19th day of September, 2006.

Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Department of Labor and Workforce Development, Division of Workers' Compensation, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department's ADA Coordinator, Mr. Jewel Crawford, at Andrew Johnson Tower, 8th Floor, 710 James Robertson Parkway, Nashville, Tennessee 37243-0655 and (615) 741-8805.

For a copy of the entire text of this notice of rulemaking hearing contact: Rhonda Hutt, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 532-1471.

SUBSTANCE OF PROPOSED AMENDMENTS TO RULES

CHAPTER 0800-2-18
MEDICAL FEE SCHEDULE

AMENDMENTS

0800-2-18-.02 GENERAL INFORMATION AND INSTRUCTIONS FOR USE

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

(a) Unless otherwise indicated herein, the most current, effective Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the most current effective CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. For purposes of these Rules, the base Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index

adjustment, but the maximum allowable amount of reimbursement under these Rules shall not fall below the effective 2005 Medicare amount for at least two (2) years from 2005. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in the Medical Cost Containment Program Rules at 0800-2-17-.03(80).

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

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

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

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

Subparagraph (a) of paragraph (4) of rule 0800-2-18-02 General Information and Instructions for Use is amended by deleting the words "100% of Medicare's LUPA" and replacing it with the words "Usual and Customary Amount," so that as amended the subparagraph shall read:

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

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

Radiology.....$75.80 200%

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

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

(b) The appropriate conversion factor must be determined by the type of CPT code for the procedure performed in all cases except those involving orthopedic and neurosurgery. The appropriate conversion factor for all surgical CPT codes for surgical procedures by any physician other than certified and board-eligible neurosurgeons and orthopedic surgeons is $75.80, (200% of national Medicare rates). Board-eligible and certified neurosurgeons and orthopedic surgeons shall use the neurosurgery and orthopedic surgery conversion factors for all surgery CPT codes. Evaluation and management CPT codes require the use of the associated conversion factor of $60.64 (160% of National Medicare rates) by all
physicians, including neurosurgeons and orthopedic surgeons.

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

0800-2-18-.07 AMBULATORY SURGICAL CENTERS AND OUTPATIENT HOSPITAL CARE (INCLUDING EMERGENCY ROOM FACILITY CHARGES)

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

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

1. Physician services
2. Laboratory services
3. Radiology services
4. Diagnostic procedures not related to the surgical procedure
5. Prosthetic devices
6. Ambulance services
7. Orthotics
8. Implantables

9. DME for use in the patient's home

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

11. Take home medications

12. Take home supplies

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

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

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

(j) The listed services and supplies in subsection (1)(h) above shall be reimbursed according to the Medical Fee Schedule Rules, or at the usual and customary amount, as defined in these Rules, for items/services without an appropriate Medicare payment amount and not specifically addressed in the Medical Fee Schedule Rules.

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

(l) Pre-admission lab and x-ray may be billed separately from the Ambulatory Surgery bill when performed 24 hours or more prior to admission, and will be reimbursed the lesser of billed charges or the payment limit of the fee schedule. Pre-admission lab and radiology are not included in the facility fee.

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

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

0800-2-18-.09 PHYSICAL AND OCCUPATIONAL THERAPY GUIDELINES

Paragraph (1) of rule 0800-2-18-.09 Physical and Occupational Therapy Guidelines is amended by deleting the word "of" before "$10,000" in the first sentence, replacing it with the words "up to" before "$10,000.00," and adding the following at the end of the first sentence after the word "Commissioner," ", for any physician who is not validly and currently board-certified by the American Board of Medical Specialties in one of the following four (4) specialties to refer a patient to a "physician-affiliated" facility for physical therapy or occupational therapy: Orthopedic Surgery, Neurological Surgery, Physiatry or Occupational Medicine. Supporting written documentation shall be maintained showing all patients have been fully informed they have the right to go to a facility of their choosing and full disclosure in writing shall be made of any financial or beneficial interest held by any physician referring a patient to a physician-affiliated facility," so that as amended the paragraph shall read:

(1) It shall be a violation of these Rules, and may result in a civil penalty of up to $10,000.00 per violation, as determined by the Commissioner, for any physician who is not validly and currently board-certified by the American Board of Medical Specialties in one of the following four (4) specialties to refer a patient to a "physician-affiliated" facility for physical therapy or occupational therapy: Orthopedic Surgery, Neurological Surgery, Physiatry or Occupational Medicine. Supporting written documentation shall be maintained showing all patients have been fully informed they have the right to go to a facility of their choosing and full disclosure in writing shall be made of any financial or beneficial interest held by any physician referring a patient to a physician-affiliated facility. For the purpose of these Medical Fee Schedule Rules, a "physician-affiliated" facility is one in which the referring physician (or her or his immediate family, which includes spouses, parents, children or spouses of children of the referring physician) or any of the referring physicians' partners associated together in clinical practice has any type of financial interest, which includes, but is not limited to, any type of ownership, interest, debt, loan, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or any other form of direct or indirect benefit of any kind, whether in money or otherwise. Any hospital-based PT or OT facility shall also be deemed "physician-affiliated" if the referring physician is an employee of such hospital in which the facility is located, or if he or she receives a benefit of any kind from the referral.

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

Subparagraph (a) of paragraph (1) of rule 0800-2-18-.09 Physical and Occupational Therapy Guidelines is amended by deleting the current language of the subparagraph in its entirety and adding a new subparagraph so that as amended the subparagraph shall read:

(a) Notwithstanding any provision to the contrary, the physicians board-certified by the American Board of Medical Specialties in at least one of the four (4) medical specialties listed above in Rule 0800-2-18-.09(1) may refer a patient to a physician-affiliated facility if that physician determines it is in the patient's best interest to refer the patient to a specific physician-affiliated facility for rehabilitation. Any physician may refer a patient to a physician-affiliated facility if there is no other physical therapy or occupational therapy facility within fifteen (15) miles of that patient's residence or of the referring physician's office.

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

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

(2) Charges for physical and/or occupational therapy services shall be reimbursed on a sliding scale based on the number of visits. The number of visits shall start over whenever surgery related to the injury is performed. Reimbursement shall not exceed one hundred fifty percent (150%) of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule) for the first six (6) visits, and shall not exceed one hundred thirty percent (130%) for visits 7 through 12. For all visits after visit 12, reimbursement shall not exceed one hundred percent (100%).

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

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

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

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

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

(6) Whenever physical therapy and/or occupational therapy services are prescribed, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in Chapter 0800-2-6 of the Division's Utilization Review Rules and in accordance with Tenn. Code Ann. § 56-6-705 before physical therapy and/or occupational therapy services may be certified for payment by the carrier. Notification of a determination by the utilization review agent shall be mailed or otherwise communicated through electronic mail, facsimile and/or telephone to the provider of record or the enrollee or other appropriate individual within two (2) business days of the receipt of the request for determination and the receipt of all information necessary to complete the review from the carrier or employer. Failure of a provider to promptly (at least seven (7) business days before the last approved treatment is rendered) and properly and timely request utilization review of such services as prescribed herein shall result in the forfeiture of any payment for non-approved services. However, failure by carrier or employer to communicate denial or approval of a properly submitted request for utilization review within five (5) business days of the receipt of the request for determination and the receipt of all information necessary to complete the review shall be deemed an approval of the treatment requested. The initial utilization review of physical therapy and/or occupational therapy services may, if necessary and appropriate, certify up to six (6) visits. Subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services after six (6) visits to the PT or OT facility. Further utilization review is required after each six (6) visit increment.

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

The notice of rulemaking set out herein was properly filed in the Department of State on the 20th day of June, 2006. (06-25)