Notice of Rulemaking Hearing

Tennessee Department of Labor and Workforce Development
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 new rules pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-204 and 50-6-204. 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 First Floor Conference Room of the Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243 at 9:00 a.m. CDT on the 28th day of August, 2007.

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: E. Blaine Sprouse, 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) 253-8937.

Substance of Rule Amendments

Chapter 0800-02-18
Medical Fee Schedule

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Paragraph (1) of Rule 0800-02-18-.01 Medicare-Basis for System, Applicability, Effective Date and Coding References is amended by deleting the paragraph in its entirety and replacing it with a new paragraph, so that as amended the new paragraph (1`) shall read:

(1) The Medical Fee Schedule of the Tennessee Division of Workers' Compensation ("TDWC") is a Medicare-based system, but with multiple conversion factors. These Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Act. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration's) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' relative value units ("RVUs") which must be adjusted for the Tennessee Geographic Practice Index ("GPCI") and the Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation in

these Rules. These Medical Fee Schedule Rules must be used in conjunction with the current American Medical Association's ("AMA's") CPT Code Guide, the Health Care Financing Administration Common Procedure Coding System ("HCPCS"), the current and effective AMA's Medicare RBRVS: The Physicians' Guide, the American Society of Anesthesiologists ("ASA") Relative Value Guide, and current effective Medicare procedures and guidelines.

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

0800-02-18-.02 General Information and Instructions for Use

Subparagraph (a) of paragraph (2) of rule 0800-02-18-02 General Information and Instructions for Use is amended by deleting the word "most" in the first, second and third sentences, as well as the phrase "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," at the end of the fourth sentence, so that as amended the new subparagraph (a) shall read:

(a) Unless otherwise indicated herein, the 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 current effective CMS' Medicare allowable amount. The 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. 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).

Subparagraph (a) of paragraph (3) of rule 0800-02-18-02 General Information and Instructions for Use is amended by deleting the subparagraph in its entirety and replacing it with a new subparagraph so that as amended the new subparagraph (a) shall read:

(a) The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT code by multiplying the CMS relative value units ("RVUs") by CMS' Tennessee specific Geographic Practice Cost Index ("GPCI") to establish Tennessee specific RVUs, then multiplying the adjusted Tennessee total RVUs by the appropriate Medical Fee Schedule conversion factor. Whether one uses the facility or nonfacility RVUs is determined using the current, effective Medicare guidelines and is dependent upon the location at which the service is provided. Certain specialty areas listed below do not have a specific conversion factor and the maximum reimbursement amount allowed is the usual and customary amount (defined in the Medical Cost Containment Rules at 0800-2-17-.13(80)), as indicated. For areas not listed, the maximum allowable amount is 100% of the Tennessee specific Medicare allowable amount calculated in accordance with Medicare guidelines and methodology.

Paragraph (4) of rule 0800-02-18-02 General Information and Instructions for Use is amended by deleting the year "2006" and replacing it with the year "2007" so that as amended the new paragraph (4) shall read:

(4) Monetary Conversion Factors are based on the CMS' 2007 unit amount of $37.8975. These Factors are subject to change based upon any change in the Medicare unit amount.

Subparagraph (a) of paragraph (4) of rule 0800-02-18-02 General Information and Instructions for Use is amended by deleting the current subparagraph and replacing it so that as amended the new subparagraph (a) shall read:

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

	Conversion Factor	As a Percentage of Medicare
Anesthesiology	$75.00	N/A
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) (Surgery by non-board eligible physicians paid general surgery rate)	$104.14	275%
Orthopedic Surg. (board-eligible or cert. physicians) (Surgery by non-board eligible physicians paid general surgery rate)	$104.14	275%
Pathology	Usual and Customary Amount	
Physical and Occupational Therapy	$49.27	130%
Radiology	$75.80	200%

Subparagraph (b) of paragraph (4) of rule 0800-02-18-02 General Information and Instructions for Use is amended by deleting the current subparagraph and replacing it so that as amended the new subparagraph (b) 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 Tennessee 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 Tennessee Medicare rates) by all physicians, including neurosurgeons and orthopedic surgeons.

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

Subparagraph (b) of paragraph (1) of Rule 0800-02-18-.05 Anesthesia Guidelines is amended by deleting the current subparagraph and replacing it in its entirety so that as amended the new subparagraph (b) shall read:

(b) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, maximum reimbursement shall be 90% of the maximum allowable fee for anesthesiologists under these Medical Fee Schedule Rules. No payment will be made to the surgeon supervising the CRNA.

Subparagraph (c) of paragraph (1) of Rule 0800-02-18-.05 Anesthesia Guidelines is amended by deleting the current subparagraph and replacing it in its entirety so that as amended the new subparagraph (c) shall read:

(c) Whenever anesthesia services are provided by an anesthesiologist or other physician and a CRNA, reimbursement shall never exceed 100% of the maximum amount anesthesiologist or physician would have been allowed under these Medical Fee Schedule Rules had the anesthesiologist alone performed the services.

Subparagraph (a) of paragraph (5) of Rule 0800-02-18-.05 Anesthesia Guidelines is amended by deleting the current subparagraph and replacing it in its entirety so that as amended the new subparagraph (a) shall read:

(a) Reimbursement for anesthesia services shall not exceed the maximum allowable Medical Fee Schedule amount of $75.00 per unit.

Subparagraph (a) of paragraph (6) of Rule 0800-02-18-.05 Anesthesia Guidelines is amended by deleting the current subparagraph and replacing it in its entirety so that as amended the new subparagraph (a) shall read:

(a) When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and post-operative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post-anesthesia recovery areas, except in an appropriately documents extreme emergency situations. Total reimbursement for the nurse anesthetist and the anesthesiologist shall not exceed the maximum amount allowable under the Medical Fee Schedule Rules had the anesthesiologist alone performed the services.

Subpart (ii) of part 1. of subparagraph (b) of paragraph (7) of Rule 0800-02-18-.05 Anesthesia Guidelines is amended by deleting the phrase "the provider's usual and customary charge" at the end of the subpart and replacing it with the phrase "the maximum amount allowable under these Medical Fee Schedule Rules of $75.00 per unit" so that as amended the new subpart (ii) shall read:

(ii) Reimbursement shall not exceed the maximum amount allowable under these Medical Fee Schedule Rules of $75.00 per unit.

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

Subparagraph (f) of paragraph (1) of Rule 0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges) is amended by deleting the number "85%" and replacing it with the number "80%" in the last sentence, so that as amended the new subparagraph (f) shall read:

(f) Status indicators used under Medicare should be interpreted using Medicare guidelines with the exception of status indicator "C," which Medicare does not reimburse for outpatient services, but requires inpatient treatment. Under these Rules, these procedures listed with status indicator "C" performed on an outpatient basis shall be reimbursed, but with the maximum amount being usual & customary, which is 80% of the billed charges, as defined in the Division's Rule 0800-2-17-.03(80).

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

Paragraph (1) of Rule 0800-2-.09 Physical and Occupational Therapy Guidelines is amended by deleting the current paragraph completely and replacing it, and by deleting subparagraphs (a) and (b) of paragraph (1) of Rule 0800-2-.09 in their entirety, so that as amended the new paragraph (1) shall read:

(1) Reimbursement for all physical and occupational therapy services shall not exceed one hundred thirty percent (130%) of the maximum allowable fees prescribed in the Medicare RBRVS fee schedule, no matter where the services are performed.

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

Paragraph (2) of Rule 0800-2-.09 Physical and Occupational Therapy Guidelines is amended by deleting that paragraph completely, deleting paragraph (4) in its entirety and replacing it with a new paragraph, and renumbering paragraphs (3) through (6) as new paragraphs (2) through (5), so that as amended the new paragraphs shall read:

(2) For physical therapy and/or occupational therapy, there shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.

(3) For physical therapy and/or occupational therapy, there shall be no fee allowable for any modalities or therapeutic procedures performed in excess of four (4) modalities, therapeutic procedures, or combination thereof per day per employee. The definitions of modality and therapeutic procedures from the American Medical Association's Current Procedural Terminology (CPT) 2005 edition are applicable.

(4) 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.

(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 0800-2-6 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within two (2) business days of any request for certification to assure no interruption in delivery of needed services. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of 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 and 50-6-233.

Subparagraph (b) of paragraph (1) of Rule 0800-02-18-.10 Durable Medical Equipment and Implant Guidelines is amended by adding the sentence "The maximum allowable rental fee for DME is 100% of the Tennessee Medicare allowable amount" after the first full sentence ending with "(30-60 days)", so that as amended the new subparagraph (b) shall read:

(b) Rental/Purchase. Rental fees are applicable in instances of short-term utilization (30-60 days). The maximum allowable rental fee for DME is 100% of the Tennessee Medicare allowable amount. If it is more cost effective to purchase an item rather than rent it, this must be stressed and brought to the attention of the insurance carrier. The first month's rent should apply to the purchase price. However, if the decision to purchase an item is delayed by the insurance carrier, subsequent rental fees cannot be applied to the purchase price. When billing for rental, identify with modifier "RR".

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

Paragraph (1) of Rule 0800-02-18-.11 Orthotics and Prosthetics Guidelines is amended by deleting the word "national" in the third sentence and replacing it with the word "Tennessee" so that as amended the new paragraph (1) shall read:

(1) Orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System (HCPCS). Copies may be obtained from the American Orthotic and Prosthetic Association, 1650 King Street, Suite 500, Alexandria, VA 22314, (703) 836-7116. Orthotics and prosthetics shall be reimbursed up to a maximum of 115% of the 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 and 50-6-233.

The notice of rulemaking set out herein was properly filed in the Department of State on the 28th day of June, 2007. (FS 06-34-07, DBID 662)