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Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Department of Labor and Workforce Development
Division:	Workers' Compensation
Contact Person:	Landon Lackey
Address:	220 French Landing Drive Nashville, Tennessee 37243
Phone:	615-532-0370
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Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	Evelyn Gaines-Guzman
Address:	220 French Landing Drive Nashville, TN 37243
Phone:	615-253-1331
Email:	evelyn.gaines.guzman@tn.gov

Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	TN Department of Labor and Workforce Development 220 French Landing Drive
Address 2:	Tennessee Room, 1st Floor, Side A
City:	Nashville
Zip:	37243
Hearing Date :	09/28/2011
Hearing Time:	10:00 a.m. _x_ CST ___ EST

Additional Hearing Information:

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**
0800-02-12	Drug Free Workplace Programs
Rule Number	**Rule Title**

0800-02-12-.03	Definitions
0800-02-12-.07	Testing

Chapter Number	**Chapter Title**
0800-02-17	Medical Cost Containment Program
Rule Number	**Rule Title**
0800-02-17-.06	Procedures for Which Codes Are Not Listed
0800-02-17-.09	Independent Medical Examination to Evaluate Medical Aspects of Case
0800-02-17-.10	Payment
0800-02-17-.12	Recovery of Payment
0800-02-17-.20	Utilization Review
0800-02-17-.21	Process for Resolving Differences Between Carriers and Providers Regarding Bills
0800-02-17-.24	Provider and Facility Fees for Copies of Medical Records

Chapter Number	**Chapter Title**
0800-02-18	Medical Fee Schedule
Rule Number	**Rule Title**
0800-02-18-.02	General Information and Instructions for Use
0800-02-18-.04	Surgery Guidelines
0800-02-18-.05	Anesthesia Guidelines
0800-02-18-.07	Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges)
0800-02-18-.08	Chiropractic Services Guidelines
0800-02-18-.09	Physical and Occupational Therapy Guidelines
0800-02-18-.10	Durable Medical Equipment and Implant Guidelines
0800-02-18-.12	Pharmacy Schedule Guidelines
0800-02-18-.13	Ambulance Services Guidelines

Chapter Number	**Chapter Title**
0800-02-19	In-patient Hospital Fee Schedule
Rule Number	**Rule Title**
0800-02-19-.03	Special Ground Rules – Inpatient Hospital Services

(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)

Notice of Rulemaking Hearing for Rules
of
Tennessee Department of Labor and Workforce Development

Chapter 0800-02-12
Drug Free Workplace Programs

Amendments

Rule 0800-02-12-.03 Definitions, subsection (17)(a) is amended by deleting the current language and replacing it with the following:

(17) (a) "Prohibited Levels" for a drug or a drug's metabolites means cut-off levels on screened specimens which are equal to or exceed the following and shall be considered to be presumptively positive;

1. Cut-off levels on initially screened specimens:

Amphetamines	500 ng/mL
Marijuana (cannabinoids)	50 ng/mL
Cocaine (benzolylecgonine)	150 ng/mL
Opiates (codeine, morphine, heroin)	2,000 ng/mL
PCP (phencyclidine)	25 ng/mL
6-Acetylmorphine (heroin)	10 ng/mL
MDMA (ecstasy)	500 ng/mL

2. Cut-off levels on confirmation specimens:

Amphetamines	250 ng/mL
Marijuana (cannabinoids)	15 ng/mL
Cocaine (benzolylecgonine)	100 ng/mL
Opiates (codeine, morphine, heroin)	2,000 ng/mL
PCP (phencyclidine)	25 ng/mL
6-Acetylmorphine (heroin)	10 ng/mL
MDMA (ecstasy)	250 ng/mL

Authority: T.C.A. §§50-9-103, 50-9-106, 50-9-109, and 50-9-111.

Rule 0800-02-12-.07 Testing, section (1) is amended by adding two new subsections, which shall read:

(g) 6-Acetylmorphine (heroin)
(h) MDMA (ecstasy)

Authority: T.C.A. §§50-9-101(a) and (b), 50-9-104, 50-9-106(a)(1), 50-9-107(a) and (c), 50-9-110, and 50-9-111.

Chapter 0800-02-17
Medical Cost Containment Program

Amendments

0800-02-17-.06 Procedures for Which Codes Are Not Listed, section (1) is amended by deleting the current language and replacing it with the following:

(1) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale ("RBRVS"), the health care provider must use an appropriate CPT procedure code or revenue code, as applicable. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the bill).

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

0800-02-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case, section (2) is amended by adding the following sentence at the end:

Physicians may only require pre-payment of $500.00 for an IME; provided, that following the completion of the IME and report, the physician may bill for other amounts appropriately due and the payer can recover any amounts that were overpaid.

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

0800-02-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case is amended by adding the following as a new section (4):

(4) Physicians who perform consultant services and/or records review in order to determine whether to accept a new patient shall not bill for an IME. Rather, such physicians shall bill using CPT codes 99358 and 99359. The reimbursement shall be $200.00 for the first hour of review and $100.00 for each additional hour; provided, that each quarter hour shall be pro-rated.

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

0800-02-17-.10 Payment, section (4) is amended by adding the following sentence at the end:

If the Division does not designate a specific form, then the proper form shall be according to Medicare guidelines.

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

0800-02-17-.10 Payment, section (12) is amended by deleting the current language and replacing it with the following:

(12) Payments to providers for initial examinations and treatment authorized by the carrier or employer shall be paid by that carrier or 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).

0800-02-17-.12 Recovery of Payment, section (1) is amended by adding the following sentence at the end:

If the timeframes in these Rules are not met, then the Medical Care and Cost Containment Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

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

0800-02-17-.20 Utilization Review, subsection (1)(a) is amended by changing "Tenn. Code Ann. § 50-6-102(18)" to "Tenn. Code Ann. § 50-6-102(17)."

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).

0800-02-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills, subsection (4)(b) is amended by deleting the first sentence and replacing it with the following:

(b) Valid requests for Administrative Review must be accompanied by a form prescribed by the Division, must be legible, and must contain copies of the following:

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

0800-02-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills, section (4) is

amended by adding the following as a new subsection (d):

(d) If the request for review does not contain proper documentation, then the MCCCC will decline to review the dispute. Likewise, if the timeframes in this Rule are not met, then the MCCCC will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

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

0800-02-17-.24 Provider and Facility Fees for Copies of Medical Records, section (1) is amended by adding the following sentence at the end:

The cost set forth in this subsection shall also apply to paper records transmitted on a disc or by other electronic means based upon the number of pages reproduced on the disc or other media.

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

0800-02-17-.24 Provider and Facility Fees for Copies of Medical Records, section (2) is amended by deleting the current language and replacing it with the following:

(2) Health care providers and facilities must furnish an injured employee or the employee's attorney and carriers/self-insureds or their legal representatives copies of records and reports as set forth in Tenn. Code Ann. § 50-6-204, as amended.

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

Chapter 0800-02-18
Medical Fee Schedule

Amendments

0800-02-18-.02 General Information and Instructions for Use, subsection (2)(b) is amended by adding the following as a new subsection:

6. The "lesser of" comparison in these Rules should be determined based on the entire bill or amount due for a particular service, rather than on a line-by-line basis.

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

0800-02-18-.02 General Information and Instructions for Use, section (4) is amended by deleting the section in its entirety and replacing it with the following:

(a) Practitioner fees shall be based on the most current Tennessee Medicare rates. The conversion factors listed below should be applied to the CPT code in order to calculate the appropriate amount. In no event shall the amount be determined by the practitioner's certification or eligibility status with any specialty board.

Service Category	TN Conversion Factor
Anesthesiology	$75.00 per unit
Surgery	
(Codes 20000-29999 & 61000-64999)	275% of current Medicare
(all other surgical codes)	200% of current Medicare
Radiology	200% of current Medicare
Pathology	200% of current Medicare
Physical/Occupational Therapy	130% of current Medicare

Chiropractic.....130% of current Medicare

General Medicine
(including evaluation & management).....160% of current Medicare

Emergency Care.....130% of current Medicare

Dentistry.....100% of current Medicare

(b) Notwithstanding subsection (a), if the most current Medicare conversion factor falls below 30.00, then 30.00 shall be used to calculate the amounts in subsection (a) in lieu of the most current Medicare conversion factor until such time as the most current Medicare conversion factor exceeds 30.00.

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

0800-02-18-.04 Surgery Guidelines, section (1) is amended by deleting the current language and replacing it with the following:

(1) Multiple Procedures: Reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus 50% of the lesser or secondary procedure(s). The major procedure shall be determined to be the procedure with the highest Medicare reimbursement.

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

0800-02-18-.05 Anesthesia Guidelines, subsection (1)(b) is amended by adding the following sentence at the end:

Only anesthesiologists providing medical direction pursuant to subsection (6) may receive additional reimbursement; provided, that the combined reimbursement for the anesthesiologist and CRNA shall not exceed 100% of the maximum allowable fee.

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

0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), subsection (1)(c) is amended by deleting the current language and replacing it with the following:

(c) Under the Medical Fee Schedule Rules, the OPPS reimbursement system shall be used for reimbursement for all outpatient services, wherever they are performed, in a free-standing ASC or hospital setting. The most current, effective Medicare APC rates shall be used as the basis for facility fees charged for outpatient services and shall be reimbursed at a maximum of 150% of current value for such services. Depending on the services provided, ASCs and hospitals may be paid for more than one APC for an encounter. When multiple surgical procedures are performed during the same surgical session, reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus 50% of the lesser or secondary procedure(s); provided, that the major procedure shall be determined to be the procedure with the highest Medicare reimbursement. Only separate and distinct surgical procedures shall be billed. Medicare guidelines shall be consulted and used in determining separate and distinct surgical procedures.

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

0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), subsection (1)(h)(2) is amended by deleting the current language and replacing it with the following:

2. Laboratory Services (including pathology)

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

0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), subsection (k) is amended by deleting the current language and replacing with the following:

(k) There may be emergency cases or other occasions in which the patient was scheduled for outpatient surgery and it becomes necessary to admit the patient. All hospitals with ambulatory patients who stay longer than 23 hours past ambulatory surgery and are formally admitted to the hospital as an inpatient will be paid according to the In-patient Hospital Fee Schedule Rules, 0800-02-19. All ASCs shall be paid pursuant to this Rule 0800-02-18-.07 regardless of the patient's length of stay.

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

0800-02-18-.08 Chiropractic Services Guidelines, section (2) is amended by deleting the current language in its entirety and substituting instead the following:

(2) For chiropractic services, an office visit may only be billed on the same day as a manipulation when it is the patient's initial visit with that provider.

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, section (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 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; provided, that further certifications are not required to be in increments of twelve (12) visits.

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, section (1) is amended by adding the phrase "or, for hospital reimbursements, a UB 04 form." at the end of the last sentence, so that it reads 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 or, for hospital reimbursements, a UB 04 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, subsection (1)(c) is amended by deleting the phrase "subsection (5) of this section" and replacing it instead with "the following subsections."

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

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, subsection (1)(e)(1)(i) is amended by adding the phrase "or Generic Equivalent Average Price ("GEAP")" after the phrase "Average Wholesale Price* ("AWP")."

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

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, subsection (1)(e)(2)(ii) is amended by adding the phrase "or GEAP" after each reference to "AWP."

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

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, subsection (1)(e)(2)(v) is amended by deleting the reference to "Rule 0800-2-11-.10" and replacing it with "Rule 0800-02-17-.10."

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

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, subsection (1)(f)(2) is amended by deleting the reference to "(4)(b)" and replacing it with "(e)(2)."

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

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, section (1) is amended by adding a new subsection (h) at the end, which should read as follows:

(h) Repackaged or Compounded Products

All pharmaceutical bills submitted for repackaged or compounded products must include the NDC Number of the original manufacturer or distributor's stock package used in the repackaging or compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP or GEAP of the product as of the date of dispensing, rather than the repackaged or compounded NDC Number.

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

0800-02-18-.13 Ambulance Services Guidelines, section (4) is amended by deleting the current language in its entirety and replacing it with the following:

(4) Reimbursement shall be based upon the lesser of the submitted charge or 150% of the current Medicare rate. To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services.

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

Chapter 0800-02-19
In-patient Hospital Fee Schedule

Amendments

0800-02-19-.03 Special Ground Rules – Inpatient Hospital Services, subsection (4)(b)(1) is amended by adding the following sentences at the end:

Non-covered charges shall also be excluded when determining the total Allowed Charges for stop-loss calculations. Medicare bundling guidelines are not controlling when determining Allowed Charges for stop-loss calculations; rather, only the items listed in Rule 0800-02-19-.03(2)(d)(4) and non-covered charges shall be excluded in the calculations.

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

0800-02-19-.03 Special Ground Rules – Inpatient Hospital Services, subsection (4)(d) is amended by deleting the current language and replacing it with the following:

(d) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1 – Surgical admission
Maximum rate per day: $1,800 for first 7 days; 1,500 for 2 additional days

Number Billed Days: 9
Total Billed Charges (minus amounts for implants, radiology, etc.): $53,650.00

Maximum allowable payment for Normal DRG stay..... $15,600.00

Versus: billed charges $53,650.00

Amount Payable Before Stop-Loss,
Lower of Charge vs. Maximum Allowable..... $15,600.00

Total difference, charges over and above maximum payments $38,050.00

Difference over and above $15,000 Stop-loss is..... $23,050.00
Payable under Stop-loss (80% of $23,050.00).....$18,440.00

Amounts due hospital for implants, radiology, etc.....$3,525.00

Total payment
due hospital: .....15,600.00 + 18,440.00 + 3,525.00 = $37,565.00

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

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 8/5/11

Signature: Karla Davis

Name of Officer: Karla Davis

Title of Officer: Commissioner of Labor and Workforce Development

Subscribed and sworn to before me on: 8/5/11

Notary Public Signature: Cynthia Ann Key

My commission expires on: 7/23/2012

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Filed with the Department of State on: 8/8/11

Tre Hargett by Mr Hart, ATA
Tre Hargett
Secretary of State

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