Public Necessity Rules
of
The Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation

Chapter 0800-2-19
In-Patient Hospital Fee Schedule

Statement of Necessity for Readopting Public Necessity Rules

Pursuant to Tenn. Code Ann. §§ 4-5-209(a)(4) and (b) and 50-6-204(i)(5), the Commissioner submits the In-patient Hospital Fee Schedule Rules ("Rules") for readoption as public necessity rules as part of the comprehensive medical fee schedule and related system applicable to all medical treatment under the Workers' Compensation Law as administered by the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development. Readoption of these as public necessity rules is necessary for the reasons set forth below and because Tenn. Code Ann. § 50-6-204(i) requires the comprehensive medical fee schedule and related system be in place and effective on and after July 1, 2005. Tenn. Code Ann. § 50-6-204(i)(5).

These Rules were initially adopted as public necessity rules and filed with the secretary of state's office on June 15, 2005, when proposed rules were also filed. Those public necessity rules will expire on November 27, 2005, and unless these rules are readopted as public necessity rules now, there will be a period of time when no effective Rules will be in place. In response to a petition on the proposed rules, a rulemaking public hearing was held on these Rules on September 23, 2005. The Department is currently analyzing all of the numerous oral and written comments received during the rulemaking public hearing and must respond to each in writing as required pursuant to Tenn. Code Ann. § 4-5-222. Given that the rulemaking hearing rules may not be effective until at least 75 days after filing with the secretary of state's office, it would be impossible to avoid a lapse in these Rules without the readoption of these Rules as public necessity rules. The Department could not have reasonably foreseen during the initial one hundred sixty-five day period that the original need for the public necessity rules would continue to the present time.

Medical providers, employees, employers and insurers are statutorily mandated to comply with the medical fee schedule rules, of which these Rules are an integral part, on and after July 1, 2005, in providing all workers' compensation medical benefits. These rules are necessary to comply with the mandate enacted by the General Assembly in Public Chapter 962 (Tenn. Code Ann. § 50-6-204, (2005 Supp.)) to provide the required medical fee schedule with guidelines and procedures to medical providers, employees, employers and insurers. Thus, these public necessity rules are being readopted to protect the public welfare. Due to the length of time necessary to complete the rulemaking process under the Uniform Administrative Procedures Act, these public necessity rules should be readopted immediately to provide applicable medical fees, guidelines and procedures so as not to jeopardize injured employees' ability to receive prompt and adequate medical care. Further, Tenn. Code Ann. § 50-6-204(i)(5) specifically authorizes adoption of these rules as public necessity rules.

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James Neeley, Commissioner
Tennessee Department of Labor &
Workforce Development

For copies of this public necessity rule contact: Vickie Gregory, 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) 253-1613.

New Rules

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0800-2-19-.01 General Rules

(1) This In-patient Hospital Fee Schedule shall be effective July 1, 2005 and is applicable for all inpatient services as defined herein, and includes medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured workers under the Tennessee Workers' Compensation Act. Maximum fees for outpatient hospital services are not addressed in this In-patient Hospital Fee Schedule, but are contained in the Medical Fee Schedule Rules, 0800-2-18-.01 et seq. This In-patient Hospital Fee Schedule is established pursuant to Tenn. Code Ann. § 50-6-204 (Supp. 2004) is effective July 1, 2005, and must be used in conjunction with the Medical Cost Containment Program Rules, 0800-2-17-.01 et seq. and the Medical Fee Schedule Rules, 0800-2-18-.01 et seq. as the definitions and general provisions set forth in those rules are incorporated as if set forth fully herein.

(2) General Information

(a) Reimbursements shall be determined for services rendered in accordance with this fee schedule and shall be considered to be inclusive unless otherwise noted.

(b) The most current 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. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the amount of reimbursement shall be at 100% of the 2005 CMS' Medicare amount and the most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. The Medicare amount may, at the Commissioner's discretion, be adjusted upward annually based upon CMS' annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount and be billed By Report.

(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 Inpatient Hospital Fee Schedule.

(d) Inpatient hospitals shall be grouped into the following separate peer groupings:

Peer Group	1	Hospitals
Peer Group	2	Rehabilitation Hospitals
Peer Group	3	Psychiatric Hospitals

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

(f) The inpatient hospital fee schedule shall become effective July 1, 2005 and shall be reviewed annually and may be updated annually.

(g) Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.

(h) Preauthorization is required for specific inpatient services.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.02 Definitions

(1) "Administrator" means the chief administrative officer of the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

(2) "Allowed Charges" or "Allowable Charges" shall mean charges reviewed and approved under an appropriate audit and utilization review by the carrier as prescribed in the Division's Rules, or as determined by the Commissioner or the Commissioner's designee after consultation with the Division's Medical Director.

(3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.

(4) "Division" means the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

(5) DRG – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.

(6) In-patient Services - Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.

(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.

(9) Medical Admission - Any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.

(10) Stop-Loss Payment ("SLP") - An independent method of payment for an unusually costly or lengthy stay.

(11) Stop-Loss Reimbursement Factor ("SLRF") - A factor established by the 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 Division, 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 there is an operating room charge, the patient has a surgical procedure code, or the patient has a surgical DRG as defined by the CMS.

(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. 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. Includes costs related to transportation of patient to obtain medical care.

(15) "Trauma Admission" - means any hospital admission in which the patient has a diagnosis code of 800 to 959.99.

(16) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by this rule.

(17) 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. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.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 two (2) groups based on type of admission (surgical or non-surgical (medical)) and length of stay (less than eight (8) days/over seven (7) days). Rehabilitation and Psychiatric hospitals are grouped separately.

(2) General Information

(a) For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (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 subject to a maximum amount per inpatient day.

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

1.	Peer Group 1	$1,800.00	Surgical adm for the first seven (7) days;
		1,500.00	per day thereafter (surgical adm.)
			Includes Intensive Care (ICU) & Critical Care (CCU)
		1,500.00	Medical adm. for first seven (7) days;
		1,250.000	per day thereafter (medical adm.)

2.	Peer Group 2 (Rehabilitation)	1,000.00 800.00	For the first seven (7) days; per day thereafter
3.	Peer Group 3	700.00	Psychiatric Hospitals (applicable to chemical dependency as well.)

(c) All trauma care at any licensed Level 1 Trauma Center shall be reimbursed at a maximum rate of $3,000.00 per day for each day of patient stay.

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

1. 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.

2. Non-covered charges are: convenience items, charges for services not related to the work injury/illness services that were not certified by the payer or their representative as medically necessary.

3. Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). The reimbursement for the implantables is limited to hospital's cost plus fifteen percent (15%) of invoice, up to a maximum of invoice plus $1,000.00. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables must be accompanied by an invoice when requested by the payer.

4. 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 HCPCS code.

(i) Durable Medical Equipment
(ii) Orthotics and Prosthetics
(iii) Implantables
(iv) Ambulance Services
(v) Take home medications and supplies

(e) The above listed items will be reimbursed according to the Medical Cost Containment Program Rules and Medical Fee Schedule Rules payment limits. Items not listed in the fee schedule Rules will be reimbursed at the usual and customary rate, unless otherwise indicated herein.

(f) Per diem rates are all inclusive (with the exception of those items listed in 4 above). The services must be medically necessary and delivered at the appropriate level/site of service.

(g) 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.

(3) Reimbursement Calculations

(a) Explanation

1. Each admission is assigned an appropriate DRG.

2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission.

3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission.

(b) Formula: LOS X SPDA = WCRA

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

Hospital Peer Group: 1-Surgical admission:
Maximum rate per day: $1,800 first seven (7) days/$1,500 per day each day thereafter
Number billed days: 9
Billed charges: $15,600

Maximum Allowable Payment: $15,600

(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.

(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 $15,000. Amounts for items set forth in rule 0800-2-19-.03(d)(4), such as implantables, DME, etc., shall not be included in determining the total Allowed Charges for stop-loss calculations.

2. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

3. 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%.

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

(c) Formula: (Additional Charges x SLRF) + Maximum Allowable Payment = WCRA

(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: $37,600.00

Maximum allowable payment for
Normal DRG stay $15,600

Versus: billed charges $37,600

Amount Payable Before Stop-Loss,
Lower of Charge vs. Maximum Allowable..... $15,600

Total difference, charges over and above maximum payments $22,000

Difference over and above $15,000 Stop-loss is $7,000.00
Payable under Stop-loss (80% of 7,000.00)..... $5,600.00

Total payment
due hospital: $21,200.00 (15,600+5,600)

(5) Billing for Inpatient Admissions

All bills for inpatient institutional services should be submitted on the standard UB-82 (HCFA 1450) form or any revision to that form approved for use by the CMS.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.04. Preauthorization.

(1) Procedures For Requesting Preauthorization

(a) The insurance carrier shall be liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subparagraph (g) of this Rule required to treat a compensable injury, when any of the following situations occur:

1. the treating doctor, his/her designated representative, or injured employee has received preauthorization from the carrier prior to the health care treatments or services;

2. the carrier has failed to communicate approval or denial of preauthorization within seven (7) business days of a provider’s request for preauthorization; or

3. when ordered by the Division.

(b) The insurance carrier shall designate an accessible direct telephone number, and may also designate a facsimile number for use by the provider or the provider’s designated representative or the injured employee to request preauthorization during normal business hours. The direct number shall be answered or the facsimile responded to, by the carrier's agent who is delegated to approve or

deny requests for preauthorization, within the time limits established in subsection (d) of this section.

(c) Prior to the date of proposed treatment or services, the provider or the provider's designated representative, shall notify the insurance carrier's delegated agent, by telephone or transmission of a facsimile, of the recommended treatment or service listed in subparagraph (g) of this Rule. Notification shall include the medical information to substantiate the need for the treatment or service recommended. If requested to do so by the carrier, the treating doctor shall also notify the insurance carrier of the location and estimated date of the recommended treatment or service, and the name of the health care provider performing the treatment or service, if other than the provider. Designated representative includes, but is not limited to, office staff, hospitals, etc.

(d) Within seven (7) business days of the provider's request for preauthorization, the insurance carrier's delegated agent shall notify the provider or the provider's designated representative, by telephone or transmission of a facsimile, of the insurance carrier's decision to grant or deny preauthorization. Failure of the carrier to communicate its approval or denial of authorization within seven (7) business days of a provider's request for preauthorization shall automatically be deemed an approval of the preauthorization request. When the insurance carrier approves preauthorization, the insurance carrier shall send written approval, or if denying preauthorization, shall send documentation identifying the reasons for denial. Notification shall be sent to the injured employee, the injured employee's representative if known, and the provider or the provider's designated representative, within 24 hours after notification of denial or approval.

(e) The insurance carrier shall maintain accurate records to reflect information regarding the preauthorization request and approval/denial process.

(f) If a dispute arises over denial of preauthorization by the insurance carrier, the doctor or the injured employee may file a Request for Assistance with a Benefit Review Specialist.

(g) The health care treatments and services requiring preauthorization are: all nonemergency hospitalizations and non-emergency transfers between facilities.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.05 Other Services

(1) Pharmacy Services

(a) Pharmaceutical services rendered as part of inpatient care are considered inclusive within the inpatient fee schedule and shall not be reimbursed separately.

(b) All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines.

(2) Professional Services

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

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.06 Penalties for Violations of Fee Schedules

(1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars ($10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the alleged violator(s) to a civil penalty of not less than one hundred dollars ($100.00) nor more than ten thousand dollars ($10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.

(2) 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) days of issuance of a Notice of Violation and, if applicable, the notice of assessment of civil penalties.

(3) The request for a hearing shall be made to the Division 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.

(4) Any request for a hearing shall be filed with the Division 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 Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.

(5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed.

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

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

The public necessity rules set out herein were properly filed in the Department of State on the 16th day of November, 2005, and will be effective from the day of filing for a period of 165 days. These public necessity rules will remain in effect through the 30th day of April, 2006.