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Sequence Number: 12-19-20
Notice ID(s): 3223
File Date: 12/21/2020

Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 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:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
Address:	220 French Landing Dr. 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

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:	Troy Haley
Address:	220 French Landing Dr. 1-B, Nashville, TN 37243
Phone:	615-532-0179
Email:	troy.haley@tn.gov

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

Address 1:	Tennessee Room		
Address 2:	220 French Landing Dr. 1-A		
City:	Nashville, TN		
Zip:	37243		
Hearing Date:	02/19/2021		
Hearing Time:	10:00 am	<input type="checkbox"/> _X_ CST/CDT	
		EST/EDT	

Additional Hearing Information:

If attending in-person, please bring identification so that you may be checked into the building.

COVID Building Entry Protocols:

As part of the Tennessee Pledge, the Bureau of Workers' Compensation observes and is compliant with the following building entry protocols:

- At this time, all persons working or meeting in the 220 French Landing building are required to wear a face mask.
- Additional personal protection equipment (PPE) such as a face shield are permitted but are not a replacement for a face mask.
- Upon entry, persons are required to complete a health screening by answering the following questions:

1. Have you been in close contact with a confirmed case of COVID-19 in the past 14 days? (Note:

This does not apply to medical personnel, first responders, or other individuals who encounter COVID-19 as part of their professional or caregiving duties while wearing appropriate PPE.)

2. Are you experiencing a cough, shortness of breath or sore throat?
3. Have you had a fever in the last 48 hours?
4. Have you had new loss of taste or smell?
5. Have you had vomiting or diarrhea in the last 24 hours?

- Persons working or meeting in the 220 French Landing building are also required to submit to a temperature screening; persons with temperatures 100.4 degrees or higher will not be permitted to enter the building. However, an opportunity will be provided to submit comments in writing instead of in-person.

NOTICE

Currently, Governor Lee's Emergency Order pertaining to COVID-19 that allows agencies to hold their meetings electronically is set to expire December 27, 2020. If it does expire on that date, then this hearing will be an in-person hearing at the location and time denoted just above. If the Emergency Order is extended beyond the scheduled date of this hearing, then this hearing will be held electronically via Webex.

In the event of an electronic hearing, members of the public may join the Webex at the following link:

<https://tngov.webex.com/tngov/j.php?MTID=m4c5efc885e8e4d9182d287a51cdab761>

Meeting Number (Access Code): 178 103 0732

Meeting password: workerscomp

It is recommended that interested persons join the Webex several minutes early to ensure adequate time to install any mandatory plugins in order to attend the electronic rulemaking hearing.

Written comments will be accepted until March 5, 2021 and can be sent to troy.haley@tn.gov.

Revision Type (check all that apply):

- 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
0800-02-17	Rules for Medical Payments
Rule Number	Rule Title
0800-02-17-.01	Purpose and Scope
0800-02-17-.03	Definitions
0800-02-17-.05	Procedure Codes, Adoption of the CMS Medicare Procedures, Guidelines and Amounts
0800-02-17-.06	Procedures for Which Codes or Values Are Not Listed
0800-02-17-.09	Independent Medical Examination to Evaluate Medical Aspects of a Case
0800-02-17-.10	Payment
0800-02-17-.15	Medical Report of Initial Visit and Progress Reports for Other than In-Patient Hospital Care
0800-02-17-.25	Impairment Ratings-Evaluations and in Medical Records

Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to

<https://sos.tn.gov/products/division-publications/rulemaking-guidelines>.

Chapter 0800-02-17-.01 is amended by deleting the prior Rule 0800-02-17-.01 and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.01 Purpose and Scope

(1) Purpose:

Pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005), this chapter, together with the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19-.01 et seq., (collectively hereinafter “Rules”) are hereby adopted by the Administrator in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of bills, enforcement procedures and appeal hearings. The Administrator promulgates these Rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers’ Compensation Law (“Law”). This chapter must be used in conjunction with the Medical Fee Schedule Rules (Chapter 0800-02-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19). The Rules establish maximum allowable fees and procedures for all medical care and services provided to any employee claiming medical benefits under the Tennessee Workers’ Compensation Law. Employers and providers may negotiate and contract or pay lesser fees as are agreeable between them, but in no event shall reimbursement be in excess of the Rules, subject to the civil penalties prescribed in the Rules, as assessed by, and in the discretion of, the Administrator, the Administrator’s designee, or an agency member appointed by the Administrator. These Rules are applicable only to those injured employees claiming benefits under the Tennessee Workers’ Compensation Law.

(2) Scope: These rules do the following:

- (a) Establish procedures by which the employer shall furnish, or cause to be furnished to an employee who sustains a personal injury, illness, or occupational disease, reasonable and necessary medical, surgical, hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal.

- (b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
- (c) Establish procedures by which a health care provider shall be paid the lesser of: (1) the provider's usual bill, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted or lower price, where applicable. Unless authorized by the administrator, in no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the Administrator's discretion, result in civil penalties of not less than fifty dollars (\$50) nor greater than five thousand dollars (\$5,000.00) per violation each assessed severally against the provider accepting such fee and the employer paying the excessive fee, if a pattern or practice of such activity is found. At the Administrator's discretion, multiple violations by a provider may subject the provider to exclusion from further participating in providing medical care to injured workers under the Law.
- (d) Identify utilization of health care and health services which is above the usual range of utilization for such services, based on medically accepted standards.
- (e) Permit review by the Bureau of the records and medical bills of any health facility or health care provider to determine if they are in compliance with these Rules.
- (f) Provide for deposition and witness fees.
- (g) Establish maximum fees for medical reports.
- (h) Provide for uniformity of billing for provider services.
- (i) Establish the effective date for implementation of these Rules. Adopt by reference as part of these Rules the International Classification of Diseases, ICD-9-CM and ICD-10-CM, the American Medical Association's CPT® and Center for Medicare and Medicaid Services (CMS-Medicare) guidelines, Medical Fee Schedule Rules (Chapter 0800-02-18), the In-patient Hospital Fee Schedule (Chapter 0800-02-19) and any amendments to them.
- (j) Establish procedures for reporting of medical claims.
- (k) Establish procedures for pre-authorization for payments of non-emergency hospitalizations, transfers between facilities, and outpatient services.
- (l) Establish procedures for imposing and collecting civil penalties for violations of these Rules.
- (m) These rules shall apply where appropriate in conjunction with electronic submission of payments (e-billing). See Rule 0800-02-26.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-125, 50-6-128, 50-6-202, 50-6-204, 50-6-205, 50-6-226, (Repl. 2005), and Public Chapters 282 & 289 (2013).

Chapter 0800-02-17-.03 is amended by deleting the prior Rule 0800-02-17-.03 and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.03 Definitions

The following definitions are for the purposes of and are applicable to the Rules for Medical Payments (Chapter 0800-02-17), the Medical Fee Schedule Rules (Chapter 0800-02-18) and the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19):

- (1) "Law" means Tennessee's Workers' Compensation Law, Tenn. Code Ann. §§ 50-6-101 et seq. as currently enacted by the Tennessee General Assembly, specifically including any future enactments by the Tennessee General Assembly involving amendments, deletions, additions, repeals, or any other modification, in any form of the Workers' Compensation Law.
- (2) "Adjust" means that an employer changes a health care provider's request for payment, including but not limited to:
 - (a) Applies the maximum fee allowable under these Rules;
 - (b) Applies an agreed upon discount to the provider's usual bill, in accordance with the requirement in T.C.A. § 50-6-215;
 - (c) Adjusts to a usual and customary amount when the maximum fee is by report;
 - (d) Reduces or denies all or part of a properly-submitted bill for payment as a result of bill review;
 - (e) Recodes a procedure.
- (3) "Administrator" means the chief administrative officer of the Bureau of Workers' Compensation or the Administrator's designee.
- (4) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place as determined by the Administrator or the Administrator's designee after consultation with the Medical Director.
- (5) "Bill" means a request by a provider submitted to an employer for payment for health care services provided in connection with a compensable injury, illness or occupational disease.
- (6) "BR" (By Report) means that the procedure is not assigned a maximum fee and requires a written description. The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:
 - (a) Copies of operative reports;
 - (b) Consultation reports;
 - (c) Progress notes;
 - (d) Office notes or other applicable documentation;
 - (e) Description of equipment or supply (when that is the bill).
- (7) "Bureau" means the Tennessee Bureau of Workers' Compensation as defined in T.C.A. § 50-6-102, an autonomous unit attached to the Tennessee Department of Labor and Workforce Development for administrative matters only pursuant to T.C.A. § 4-3-1409.
- (8) "Case" means a compensable injury, illness or occupational disease identified by the worker's name and date of injury, illness or occupational disease.
- (9) "CMS" means the U.S. Centers for Medicare & Medicaid Services (formerly Health Care Financing Administration). The rules promulgated by CMS used in these chapters are referred to as "Medicare".
- (10) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately, as defined by Medicare.

- (11) "Consultant service" means; in regard to the health care of a covered injury and illness; an examination, evaluation, and opinion rendered by a health care specialist when requested by the authorized treating practitioner or by the employee; and which includes a history, examination, evaluation of treatment, and a written report. If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service(s) cease(s) to be a consultant service.
- (12) "CPT®" means the edition of the American Medical Association's Current Procedural Terminology, in effect on the date of service.
- (13) "Critical care" has the same meaning as defined by Medicare.
- (14) "Day" means a calendar day, unless otherwise designated in these Rules.
- (15) "Diagnostic procedure" means a service which aids in determining the nature and/or cause of an occupational disease, illness or injury.
- (16) "Diagnostic Code" means the properly constructed numeric code from the International Classification of Diseases, version ICD-9-CM for dates of service before October 1, 2015. For dates of service on or after October 1, 2015, it means the properly constructed alpha-numeric code, ICD-10-CM.
- (17) "Dispute" means a disagreement between an employer and a health care provider on interpretation, payment under, or application of these Rules.
- (18) "MS-DRG" (Diagnosis Related Group) means one of the classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns as defined for Medicare.
- (19) "Durable Medical Equipment" or "DME" is equipment which:

- (a) Can withstand repeated use;
 - (b) Is primarily and customarily used to serve a medical purpose;
 - (c) Generally is not useful to a person in the absence of illness, injury or occupational disease; and
 - (d) Is appropriate for use in the home.
- (20) "Employer" shall have the same meaning as defined in T.C.A. § 50-6-102, but also includes an employer's insurer, third party administrator, self-insured employers, self-insured pools and trusts, as well as the employer's legally authorized representative or legal counsel, and agents to accomplish billing and payment transactions, as applicable.
- (21) "Established patient" has the same meaning as in the version of the CPT® and Medicare guidelines in effect on the date of service.
- (22) "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis.
- (23) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
- (24) "Follow-up care" means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum allowable payment, as defined by Medicare but does not include care for complications.
- (25) "Follow-up days" means the days of care following a surgical procedure that are included in the procedure's maximum allowable payment, as defined by Medicare but does not include care for complications.
- (26) "Follow-up visits" means the number of office visits following a surgical procedure which is included in the procedure's maximum allowable payment, as defined by Medicare but does not include care for complications.
- (27) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes, but is not limited to, a freestanding surgical outpatient facility, health maintenance organization, an industrial or other clinic, an occupational health care center, a home health agency, a visiting nurse association, a laboratory, a medical supply company, or a community mental health center.
- (28) "Health care review" means the review of a health care case or bill, or both, by an employer.
- (29) "Health Care Specialist" means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.
- (30) "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place as determined by the Administrator or the Administrator's designee after consultation with the Bureau's Medical Director.
- (31) "Incidental surgery" means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the original or covered diagnosis that is in accord with the Medicare rules.

- (32) "Independent Medical Examination" means an examination and evaluation conducted by a practitioner who has not previously been involved in providing care to the examinee. There is no doctor/therapist-patient relationship. This does not include one conducted under the Bureau's Medical Impairment Rating Registry ("MIRR") Program.
- (33) "Independent procedure" means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it according to CPT® guidelines.
- (34) "Injury" has the same meaning defined in T.C.A. § 50-6-102.
- (35) "Inpatient services" mean services rendered to a person who is formally admitted to a hospital and whose condition is such that requires Inpatient admission in accordance with industry standard guidelines.
- (36) "Institutional services" mean all non-physician services rendered within the institution by an agent of the institution.
- (37) "Maximum allowable payment" means the maximum fee for a procedure established by these Rules or the usual and customary bill as defined in these Rules, whichever is less, except as otherwise might be specified. In no event shall reimbursement be in excess of the Bureau's Medical Fee Schedule, unless otherwise authorized by the administrator. Fee collected in excess of the Bureau's Medical Fee Schedule and reported to the Bureau, may, at the Administrator's discretion, result in civil penalties of fifty dollars (\$50.00) to five thousand dollars (\$5,000.00) per violation for each violation 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 Administrator's discretion, multiple violations by a provider may subject the provider to exclusion from participating in providing workers care under the Law.
- (38) "Maximum fee" means the maximum allowable payment for a procedure established by this rule, the Medical Fee Schedule and the In-patient Hospital Fee Schedule.
- (39) "Medical admission" means any hospital admission where the primary services rendered are not surgical or in an acute care hospital where the admission is to special unit such as inpatient psychiatric or rehab beds, or in a separately licensed psychiatric or rehabilitation hospital.
- (40) "Medical Director" means the Bureau's Medical Director appointed by the Administrator pursuant to T.C.A. § 50-6-126.
- (41) "Medical only case" means a case which does not involve lost work time.
- (42) "Medical supply" means either a piece of durable medical equipment or an expendable medical supply.
- (43) "Medicare Conversion Factor" is the amount in dollars assigned to an RVU, that may be modified by Medicare. The specific factor is the one in effect on the date of service.
- (44) "Modifier code" means a 2-digit number or alphabetical designation used in conjunction with the procedure code to describe circumstances, as defined by CMS which arise in the treatment of an injured or ill employee.
- (45) "New patient" designation for billing purposes means a patient who is new to the provider according to the definitions used by Medicare on the date of service.
- (46) "Operative report" means the practitioner's written description of the surgery and includes all of the following:

- (a) A preoperative diagnosis;
 - (b) A postoperative diagnosis;
 - (c) A step-by-step description of the surgery;
 - (d) An identification of problems which occurred during surgery;
 - (e) The condition of the patient, when leaving the operating room, the practitioner's office, or the health care organization.
- (47) "Ophthalmologist" shall be defined according to T.C.A. § 71-4-102(3).
- (48) "Optician" shall mean a licensed dispensing optician as set forth in T.C.A. § 63-14-103.
- (49) "Optometrist" means an individual licensed to practice optometry.
- (50) "Optometry" shall be defined according to T.C.A. § 63-8-102(12).
- (51) "Orthotic equipment" means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.
- (52) "Orthotist" means a person skilled in the construction and application of orthotic equipment.
- (53) "Outpatient service" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities also known as ambulatory surgical centers.
- (54) "Package" means a surgical procedure that includes but is not limited to all of the following components:
- (a) The operation itself;
 - (b) Local infiltration;
 - (c) Topical anesthesia when used;
 - (d) The normal or global follow-up period and/or visits as defined by CPT®.
- (55) "Pattern of practice" means repeated, similar violations over a three-year period of the Medical Fee Schedule Rules.
- (56) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced and governed by the Board of Pharmacy.
- (57) "Practitioner" means a person licensed, registered, or certified as an audiologist, chiropractic physician, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional, or their agents used to accomplish medical records, billing and payment transactions.
- (58) "Preauthorization" for workers' compensation claims means that the employer prospectively or concurrently authorizes the payment of medical benefits. Preauthorization for workers'

compensation claims does not mean that the employer accepts the claim or has made a final determination on the compensability of the claim. Preauthorization for workers' compensation claims does not include utilization review.

- (59) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.
- (60) "Procedure" means a unit of health service.
- (61) "Procedure code" means an alpha/numeric or numeric sequence used to identify a service performed and billed by a qualified provider.
- (62) "Properly submitted and complete bill" means a request for a provider for payment of health care services submitted to the employer on the appropriate forms which are completed pursuant to this rule or the rules appropriate to electronic billing. To be properly submitted and complete, the bill shall:
 - (a) Identify:
 - 1. The injured employee who received the service;
 - 2. The employer and the responsible paying agent with information sufficient to contact the responsible party in case of a dispute or questions. This information shall be provided by the payer if the bill is adjusted, contested or rejected and shall include a clear explanation of the reasons;
 - 3. The health care provider with an IRS, NPI or other appropriate identifier;
 - 4. The medical service product;
 - 5. Other information required by the form;
 - (b) Include a valid MS-DRG, Revenue Code, CPT® or HCPCS code as applicable;
 - (c) Include a ICD-10-CM codes where necessary shall be used by all parties;
 - (d) Have attached, in legible text, all supporting documentation required for the particular bill format, including, but not limited to, medical reports and records, evaluation reports, narrative reports, assessment reports, progress reports/notes, clinical notes, hospital records and diagnostic test results that may be expressly required by law or can reasonably be expected by the payer or its agent under the laws of Tennessee.
- (63) "Prosthesis" means an artificial substitute for a missing body part.
- (64) "Prosthetist" means a person skilled in the construction and application of prosthesis.
- (65) "Provider" means a facility, health care organization, or a practitioner, or their agents to accomplish medical records, correspondences, billing and payment transactions.
- (66) "Reject" means that an employer denies partial or total payment to a provider or denies a provider's request for reconsideration. Notification of any full or partial rejection must be made within fifteen (15) business days of receipt of the bill by the employer.
- (67) "RVU"- relative value unit that is assigned under the Medicare RBRVS (Resource Based Relative Value System) in effect on the date of service.
- (68) "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is

considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition, as defined by Medicare.

- (69) "Stop-Loss Payment" or "SLP" means an independent method of payment for an inpatient hospital stay.
- (70) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the Administrator to be used as a multiplier to establish a reimbursement amount when total hospital bills have exceeded specific stop-loss dollar thresholds.
- (71) "Stop-Loss Threshold" or "SLT" means a dollar threshold of bills established by the Administrator, beyond which reimbursement is calculated by multiplying the applicable SLRF times the total dollars billed following that dollar threshold.
- (72) "Surgical admission" means any hospital admission for which the patient has a surgical MS- DRG as defined by CMS.
- (73) "Tennessee Specific Conversion Percentage" is a multiplier to be applied to an applicable service for an eligible medical specialty category. The appropriate medical specialty categories are listed in Rule 0800-02-18-.02.
- (74) "Timely filing of bills for medical services" means the period of time within which a request for payment from a provider must be billed consistent with Medicare guideline time limits.
- (75) "Timely payment" means the period of time that the employer has to remit payment to the provider.
- (76) "Transfer between facilities" means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. The transfer 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 the facility in which the patient has been admitted. The transfer between facilities shall include costs related to transportation of patient to obtain medical care.
- (77) "Usual and customary" (U&C) means eighty percent (80%) of a specific provider's billed charges.
- (78) "CMS-1500 or CMS-1450, UB04" or their successors means the most recent industry standard health insurance claim forms maintained for use by medical care providers and institutions, including the ADA form for dentists and the NCPDP WC/PC UCF for pharmacies.
- (79) "Utilization Review" means evaluation of the necessity, appropriateness, efficiency and quality of medical services, including the prescribing of one (1) or more Schedule II, III or IV controlled substances for pain management for a period of time exceeding ninety (90) days from the initial prescription of such controlled substances, provided to an injured or disabled employee based upon 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, a review of medical charges or fees, or an initial evaluation of an injured or disabled employee by a physician specializing in pain management. "Utilization review," also known as "Utilization management," does not include the evaluation or determination of causation or the compensability of a claim. For workers' compensation claims, "utilization review" is not a component of preauthorization. The employer shall be responsible for all costs associated with utilization review and shall in no event obligate the employee, health care provider or Bureau to pay for such services.

Authority: T.C.A. §§ 50-6-102, 50-6-202, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013).

Chapter 0800-02-17-.05 is amended by deleting the prior Rule 0800-02-17-.05 and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.05 Procedure Codes, Adoption of the CMS Medicare Procedures, Guidelines and Amounts

- (1) Services and medical supplies must be coded with valid procedure or supply codes of the Health Care Financing Administration Common Procedure Coding System (“HCPCS”). Procedure codes used in these rules were developed and copyrighted by the American Medical Association (“AMA”).
- (2) The editions adopted by CMS of the American Medical Association’s Current Procedural Terminology (“CPT®”), the Medicare MS-DRG table and the Medicare RBRVS in effect on the date of service or date of discharge, and the National Correct Coding Initiative edits (“NCCI”) are incorporated in these Rules and shall be used in conjunction with these Rules.
- (3) Unless otherwise explicitly stated in these Rules, 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 are effective upon adoption and implementation by Medicare.
- (4) Whenever there is no specific fee or methodology for reimbursement set forth in these Rules, then the maximum amount of reimbursement shall be at 100% of the current, effective Medicare allowable amount. The effective Medicare guidelines and procedures on the date of service shall be followed in arriving at the correct amount, subject to the requirements of Rule 0800-02-18-.02(4). The Medical Fee Schedule conversion factor and TN specific conversion percentages may be, upon review by the Administrator, adjusted periodically. Whenever there is no applicable Medicare code or methodology, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in Rule 0800-02-17-.03 of this Chapter.
- (5) Telehealth: the definitions, licensing and processes for the purpose of these rules shall be the same as adopted by the Tennessee Department of Health and Medicare. Payments shall be based upon the applicable Medicare guidelines and coding effective on the date of service for the different service providers with the exception of any geographic restriction.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233 (Repl. 2005), and Public Chapters 282 & 289 (2013).

Chapter 0800-02-17-.06 is amended by deleting the prior Rule 0800-02-17-.06 and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.06 Procedures for Which Codes or Values are Not Listed

- (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).
- (2) The CPT® contains procedure codes for unlisted procedures. These codes should only be used when there is no procedure code which accurately describes the service rendered. A special report is required. These services are reimbursed BR (by report, see 0800-02-17-.03).
- (3) Where codes or other reports are listed with a dollar amount in these Rules, conversion to RVUs may be calculated by dividing the listed dollar amount by the Medicare Conversion Factor effective on the date of service. The Tennessee Specific Conversion Percentages are **not** applied to these codes or charges.

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

Chapter 0800-02-17-.09 is amended by deleting the prior Rule 0800-02-17-.09 and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.09 Independent Medical Examination to Evaluate Medical Aspects of a Case

- (1) An Independent Medical Examination, other than one conducted under the Bureau's MIRR Program, shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. This service may be necessary in order to make a judgment regarding the current status of the injured or ill worker, or to determine the need for further health care.
- (2) An Independent Medical Examination, performed to evaluate the medical aspects of a case (other than one conducted under the Bureau's MIRR Program), shall be billed using the appropriate independent medical examination procedure, and shall include the practitioner's time only. Time spent shall include face-to-face time with the patient, time spent reviewing records, reports and studies, and time spent preparing reports. The office visit bill is included with the CPT® code, 99456, and shall not be billed separately. The total amount for an IME under this Rule shall not exceed \$500.00 per hour, and shall be pro-rated per half hour, i.e. two and one-half hours may not exceed \$1,250.00. 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.
- (3) Any laboratory procedure, x-ray procedure, and any other test which is needed to establish the worker's ability to return to work shall be identified by the appropriate procedure code established by this Rule and reimbursed accordingly.
- (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 half hour shall be pro-rated. Any prepayment request may not exceed \$200.00. Violation are subject to the penalties in section 0800-02-17-.13.

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

Chapter 0800-02-17-.10 is amended by deleting the prior Rule 0800-02-17-.10 and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.10 Payment

- (1) Reimbursement for all health care services and supplies shall be the lesser of (a) the provider's usual billed charge, (b) the maximum fee calculated according to these Rules (and/or any amendments to these Rules) or (c) the agreed contracted or published rate between the provider and the MCO/PPO pursuant to T.C.A. § 50-6-215. A licensed provider or institution shall receive no more than the maximum allowable payment, in accordance with these Rules, for appropriate health care services rendered to a person who is entitled to health care services under the Law. Any provider reimbursed or employer 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.
- (2) The edition of the Medicare RBRVS: The Physicians' Guide in effect on the date of service or date of discharge is adopted by reference as part of these Rules. The Medicare RBRVS is distributed by the American Medical Association and by the Office of the Federal Register and is also available on the Internet at www.cms.hhs.gov/home/medicare.asp. Whenever a guideline or procedure is not set forth in these Rules, the Medicare guidelines and procedures in effect on the date of service

shall be followed.

- (3) When extraordinary services resulting from severe head injuries, major burns, severe neurological injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to 150% of the professional service fees normally allowed under these Rules. Such cases shall be billed with modifier -21 or -22 (for CPT® coded procedures) and shall contain a detailed written description of the extraordinary service rendered and the need therefore. This provision does not apply to In-patient Hospital Care facility fees which are specifically addressed in the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19.
- (4) Billing for provider services shall be submitted on industry standard billing forms; UB-04, CMS-1450, CMS-1500, the ADA form for dental providers, and the NCPDP WC/PC UCF for pharmacies, or their official replacement forms. Electronic billing submissions shall be in accord with the Bureau's rules for electronic billing.
- (5) An employer's payment shall reflect any adjustments in the bill subject to the following:
 - (a) Whenever the employer's reimbursement differs from the amount billed by the provider, the employer/adjuster/bill review organization shall provide an explanation of medical benefits with current and complete contact information to the health care provider. Industry standard remark codes and a clear reason for the adjustment shall be provided.
 - (b) A provider shall not attempt to collect from the injured employee, or from the employer any amounts properly reduced by the employer.
 - (c) All such communications shall comply with all applicable Medicare and HIPAA requirements.
 - (d) Remittances for electronically submitted bills shall be in accordance with the Bureau's rules for electronic billing.
- (6) All providers and carriers shall use electronic billing and EDI, if they have the capability to do so. All such communications shall comply with all applicable Medicare and HIPPA requirements.
- (7) An employer shall date stamp medical bills and reports not submitted electronically upon receipt. Payment for all properly submitted and complete bill not disputed within 15 business days (or uncontested portions of the bill) shall be made to the provider within thirty 30 calendar days.
- (8) The employer shall notify the provider within fifteen (15) business days of receipt of the bill that it was not properly submitted and specify the reason(s).
- (9) When an employer disputes a bill submitted on paper or portion thereof, the employer shall pay the undisputed portion of the paper bill within thirty (30) calendar days of receipt of a properly submitted paper bill. For the time frames applicable to e-billing see Rule 0800-02-26-.06.
- (10) For reconsiderations, responses shall be within 30 days.
- (11) Any provider not receiving timely payment of the undisputed portion of the provider's bill may institute a collection action against the employer in a state court having proper jurisdiction over such matters to obtain payment of the bill.
- (12) Billings not submitted on the proper form, as prescribed in these Rules, the In-patient Hospital Fee Schedule Rules, and the Medical Fee Schedule Rules, may be returned to the provider for correction and resubmission. If an employer returns such billings, it must do so within 15 business days of receipt of the bill. The number of days between the date the employer returns the billing to the provider and the date the employer receives the corrected billing, shall not apply toward the thirty (30) calendar days within which the employer is required to make payment. The

rules for electronic billing shall apply to the types of forms where applicable.

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

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

Chapter 0800-02-17-.15 is amended by deleting the prior Rule 0800-02-17-.15 and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.15 Medical Report of the Initial Visit and Progress Reports for Other Than In-Patient Hospital Care

- (1) Except for inpatient hospital care, a provider shall furnish the employer with a narrative medical report for the initial visit, all information pertinent to the compensable injury, illness, or occupational disease if requested within thirty (30) calendar days after examination or treatment of the injured employee.
- (2) If the provider continues to treat an injured or ill employee who is receiving temporary disability payments (total or partial) for the same compensable injury, illness or occupational disease, the provider shall provide an updated medical report to the employer, including an assessment of functional progress toward employment (restricted or unrestricted as appropriate), at intervals not to exceed sixty (60) calendar days.
- (3) The narrative medical report or the medical office visit note including an assessment of functional progress toward employment, of the initial visit and the progress or follow-up visit shall include (in addition to applicable identifying information) all of the following information:
 - (a) Subjective complaints and objective findings, including interpretation of diagnostic tests;
 - (b) For the narrative medical report of the initial visit, the history of the injury, and for the progress report(s), significant history since the last submission of a progress report and the diagnosis;
 - (c) As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment;
 - (d) Physical limitations and expected work restrictions and length of time of those limitations and/or restrictions if applicable.
- (4) When copies of narrative medical reports required by 0800-02-17-.15(1) and (2) are requested, the provider of the requested reports shall be reimbursed at the following rates using code 99080: initial and subsequent reports - not to exceed \$10.00 for reports twenty (20) pages or less in length, and twenty-five (25) cents per page after the first twenty pages. No charge is allowed for routine office notes as these are not considered narrative reports under this Rule. No fee shall be paid if a request for medical records does not produce any records.
- (5) A medical provider shall complete any medical report required by the Bureau without charge except completion of the C-30A (Final Medical Report) or the C-32 (Standard Form Medical Report) or their replacement forms.
- (6) After an initial opinion on causation has been issued by the physician, a request for a subsequent review based upon new information not available to the physician initially, may be billed by the physician and paid by the requesting party under CPT® code 99358-9 (\$200/one hour or less and \$100 for an extra hour). No additional reimbursement is due for the initial opinion on causation or a response to a request for clarification (that does not include any new information) of a previously issued opinion on causation.

- (7) Extra time spent in explanation or discussion with an injured worker or the case manager (that is separate from the discussion with the injured worker) may be charged using CPT® code 99354-52 up to a maximum payment of forty dollars (\$40), added to a standard E/M CPT® code if the extra service exceeds 15 minutes. Use code 99354 up to a maximum of eighty dollars (\$80) if that extra service exceeds 30 minutes. The Medicare allowable fee does not apply to the service. There is no extra reimbursement if the service is less than 15 minutes.
- (8) If a provider assesses, counsels or provides behavioral intervention to a Workers' Compensation patient for substance and/or alcohol use, or for substance and/or alcohol use disorder, the provider may charge for the extra time involved using CPT® code 99408 up to a maximum of eighty dollars (\$80) in addition to a standard E/M code. An assessment by structured screening must be documented. The code may only be charged if the patient is on a long term (over 90 days) Schedule II medication or a combination of one or more Schedule II, III, and/or IV medications. The Medicare allowable fee does not apply to this service.

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

Chapter 0800-02-17-.25(6) is amended by deleting the prior Rule 0800-02-17-.25(6) and replacing it with the following language, so that as amended the rule shall read:

0800-02-17-.25 Impairment Ratings – Evaluations and in Medical Records

- (6) The authorized treating physician is required and responsible for providing the impairment rating, fully completing the report on a form prescribed by the Administrator, and submitting the report to the employer, as required by these Rules, using CPT® code 99455 Notwithstanding Rule 0800-02-17-.15, the authorized treating physician shall receive payment of no more than \$250.00 for these services to be paid by the employer. The payment shall only be made to the authorized treating physician, if the authorized treating physician documents the consultation with the applicable AMA Guides™ (documentation of the analysis including section, page, or table as applicable).

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: 12/3/2020

Signature: _____



Name of Officer: Abbie Hudgens

Title of Officer: Administrator

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Tre Hargett
Secretary of State

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