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Sequence Number: 12-20-20
Notice ID(s): 3224
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	_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 State agencies to hold 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):
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**
0800-02-18	Medical Fee Schedule
Rule Number	**Rule Title**
0800-02-18-.01	Medicare-Basis for System, Applicability, Effective Date and Coding References
0800-02-18-.02	General Information and Instructions for Use
0800-02-18-.04	Surgery Guidelines
0800-02-18-.06	Injections Guidelines
0800-02-18-.09	Outpatient Physical, Speech, and Occupational Therapy Guidelines

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 0800-02-18-.01(1) is amended by deleting the prior Rule 0800-02-18-.01(1) and replacing it with the following language, so that as amended the rule shall read:

0800-02-18-.01 Medicare-Basis for System, Applicability, Effective Date, and Coding References

(1) The Medical Fee Schedule of the Tennessee Bureau of Workers' Compensation (Bureau) is a

Medicare-based system, but with multiple medical specialty Tennessee Specific Conversion Percentages. These Medical Fee Schedule Rules apply to all injured employees claiming benefits under the Tennessee Workers' Compensation Law. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' relative value units ("RVUs") which must be adjusted for the Tennessee Geographic Practice Index ("GPCI") and the Tennessee Specific Conversion Percentages adopted by the Tennessee Bureau of Workers' Compensation in these Rules. These Medical Fee Schedule Rules must be used in conjunction with the current American Medical Association's (AMA) CPT® Code Guide, CMS Common Procedure Coding System ("HCPCS"), the current and effective Resource Based Relative Value Scale (RBRVS), as developed by the AMA and CMS, the American Society of Anesthesiologists (ASA) Relative Value Guide, the National Correct Coding Initiative edits (NCCI) and current effective Medicare procedures and guidelines, unless specifically exempted in these rules. Providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers' Compensation Law may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided, upon waiver granted by the Bureau.

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

Chapter 0800-02-18-.02 is amended by deleting the prior Rule 0800-02-18-.02 and replacing it with the following language, so that as amended the rule shall read:

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

(1) Format

(a) These Rules address and consist of the following sections: General Guidelines, General Medicine (including Evaluation and Management), General Surgery, Neuro- and Orthopedic Surgery, Radiology, Pathology, Anesthesiology, Injections, Durable Medical Equipment, Implants and Orthotics, Pharmacy, Physical and Occupational Therapy, Ambulatory Surgical Centers and Outpatient Hospital Care, Chiropractic, Ambulance Services and Clinical Psychological Services. Providers should consult and use the section(s) containing the procedure(s) they perform, or the service(s) they render, together with the appropriate sections of the Rules for Medical Payments, and the In-patient Hospital Fee Schedule Rules, if applicable, and the NCPDP WC/PC UCF (National Council for Prescription Drug Programs, Property & Casualty/Workers' Compensation, Universal Claim Form) for pharmacies.

(2) Reimbursement

(a) Unless otherwise indicated herein, the most recent, effective Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the Medicare allowable amount, in effect on the date of service. The Medicare guidelines and procedures, in effect at the date of service, shall be followed in arriving at the correct amount. For purposes of these Rules, the base Medicare amount may be adjusted at the discretion of the Administrator based upon the Medicare Economic Index adjustment. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in the Rules for Medical Payments.

(b) Reimbursement to all providers shall be the lesser of the following:

1. The provider's usual charge;

2. The fee calculated according to the Medical Fee Schedule Rules (includes 100% of Medicare if no other specific fee or methodology is set forth in these Rules);

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

4. Except when a waiver is granted by the Bureau, in no event shall reimbursement be in excess of these Fee Schedule Rules that are in force on the date of service unless otherwise provided in T.C.A § 50-6-204 or in the Bureau's rules. Reimbursement in excess of the Medical Fee Schedule Rules may result in civil penalties, at the Administrator's discretion, of from $50.00 (fifty dollars) up to $5,000.00 (five thousand dollars) per violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, should a pattern or practice of such activity be found. It is recognized that providers must bill all payers at the same amount and simply billing an amount which exceeds the Fee Schedule Rules does not constitute a violation. It is acceptance and retention of an amount in excess of this Fee Schedule Rules for longer than one hundred eighty (180) calendar days that constitutes a violation by a provider. At the Administrator's discretion, multiple violations may subject the provider to exclusion from participating in the program of the Tennessee Workers' Compensation Law ("Law"). Any provider reimbursed or carrier paying an amount which is in excess of the maximum amount allowed under these Rules shall have a period of one hundred eighty (180) calendar days from the time of receipt or payment of such excessive payment in which to refund/recover the overpayment amount. If such amount is refunded or recovered within this one hundred eighty (180) calendar day time period, the overpayment shall not be considered a violation of these Rules by the provider or employer and shall not be the basis for a penalty against the provider receiving or employer paying the excessive payment.

5. The "lesser of" comparison among:

   (i) The provider's usual charge;

   (ii) The maximum allowable amount pursuant to these Rules; or

   (iii) Any other contracted amount.

   (iv) These comparisons shall be determined based on the entire bill or an amount due for a particular service, rather than on a line-by-line basis.

(3) Fee Schedule Calculations

The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT® code by multiplying the Medicare relative value units (RVU) with the Medicare Tennessee specific Geographic Practice Cost Index (GPCI) to establish the total Tennessee RVUs. That figure is then multiplied by the appropriate conversion factor to establish the base payment amount. This base payment amount is multiplied by the appropriate Medical Fee Schedule Tennessee specific conversion percentage. Whether one uses the facility or non-facility RVUs is determined using the effective Medicare guidelines on the date of service and is dependent upon the location at which the service is provided. For other areas not listed, the maximum allowable amount is 100% of the Tennessee specific Medicare allowable amount calculated in accordance with Medicare guidelines and methodology effective on the date of service, except where a waiver has been granted by the bureau.

(4)

Practitioner fees shall be based on the Medicare's Physician Fee Schedule Conversion Factor in effect on the date of service, which shall be used in conjunction with the effective Medicare RVUs on the date of service, as adjusted above. The Administrator may designate another Medical Fee Schedule conversion factor at any time. The Tennessee-Specific Conversion percentage listed below should be applied to the appropriate service category in order to calculate the correct charge or billing amount (Anesthesia by units, see Rule 0800-02-18-.05):

Anesthesiology……..……..…$75.00 per unit

Service Category by Medical Specialty	TN Specific Conversion Percentage (%)
Orthopaedics and Neurosurgery*..…….…..……275%	
General Surgery (And surgery procedure codes)…….……	200%
Radiology…….……	200%
Pathology…….……	200%
Physical/Occupational/Speech Therapy…….….	130%
Chiropractic…….....	130%
General Medicine/E&M Codes…….	160%
Occupational Medicine/Physiatrist (Physical Medicine and Rehabilitation)…….	180%

PA and APN, all services except those defined as "assistants at surgery" ……..160% of the PA or APN applicable Medicare Rate. "Incident to " Medicare rule is not billable or payable.
See 0800-02-18-.04(2) (c) for rates for assisting in surgery involving a PA or APN.

Emergency Care…..…….....	200%
Home Health Services (episodic and not "LUPA" adjustment).....	100% of Medicare
Dentistry…….…….....100% (using ADA dental codes-CDT®) See (2)(a) above and 0800-02-17-.03(74) for the complete explanation	

Oral Surgery follows the surgery percentage when using CPT® codes.

All Evaluation and Management (E/M) codes are paid at 160% (not specialty dependent).

* Board certified or Board eligible Orthopaedists and Neurosurgeons may use the modifier "ON" on the appropriate billing form when submitting surgical charges. If the modifier or another indicator is not placed on the form, then the Tennessee Department of Health's database may be consulted in order to determine the provider's specialty.

(5) Certified Physician Program in Workers' Compensation (CPP):

Physicians certified through the Certified Physician's Program shall receive an additional reimbursement for the following services:

(a) Initial Assessment (billed as an additional code Z0815) ……..……$80.00.

(b) Subsequent visit (billed as an additional code Z0816) ……..…$40.00.

(6) Forms

(a) The following forms (or their official replacements) should be used for provider billing: the effective current version of the CMS 1500 and UB 04 or the electronic equivalents.

(b) Bills for reimbursement shall be sent directly to the employer responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured

Employer. Insurance Carriers and/or Employers shall furnish this billing information to the Providers, and such information must be accurate and updated, within thirty (30) calendar days of any change to the billing address of the responsible party, either mail, e-mail or electronic submission.

(7) Violations of Fee Schedule Rules and Rules for Medical Payments

The Administrator, Administrator's Designee, or an agency member appointed by the Administrator, shall have the authority to issue civil penalties from $50.00 (fifty dollars) up to $5,000.00 (five thousand dollars) per violation for violations of the Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules or the Rules for Medical Payments ("Rules") as prescribed in the Rules. Any party notified of an alleged violation shall be entitled to a contested case hearing before the Administrator, Administrator's Designee, or an agency member appointed by the Administrator pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. §§ 4-5-101 et seq., if a written request is submitted to the Bureau by the party within fifteen (15) calendar days of issuance of notice of such violations and of any civil penalty. Failure to make a timely request will result in the violation and penalty decision becoming a final order and not subject to further review.

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 0800-02-18-.04 is amended by deleting the prior Rule 0800-02-18-.04 and replacing it with the following language, so that as amended the rule shall read:

0800-02-18-.04 Surgery Guidelines

(1) Multiple Procedures: Maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus each additional appropriately coded secondary and/or multiple procedures according to Medicare guidelines (including endoscopy and other applicable "families") and CPT® CCI edits.

(2) Services Rendered by More Than One Physician:

(a) Concurrent Care: One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.

(b) Surgical Assistant: A physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services provided by physicians, Modifier -80 or - 81, -82 shall be added to the surgical procedure code which is billed. A physician serving as a surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount. Procedures billed with the assistant-at-surgery modifiers are subject to Medicare guidelines for this service.

(c) Appropriately licensed Physician Assistants and Advance Practice Nurses (Nurse Practitioners) may serve as surgical assistants as deemed appropriate by the physician, and if so, that assistants' reimbursement shall not exceed 100% of the Physician Assistant fee or Advance Practice Nurse fee that would be due under Medicare guidelines, without regard to conversion factors or percentages applicable to their supervising physician specialty contained in this Medical Fee Schedule. These services shall be billed using the -AS modifier and are subject to the applicable Medicare assistant-at-surgery guidelines.

(d) Two Surgeons: For reporting see the most current CPT®. Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the employer has received each surgeon's individual operative report

and bill. Reimbursement to both surgeons shall be in accord with Medicare guidelines.

(e) The need for a surgical assistant, assisting surgeon, co-surgeon, second surgeon or team surgery will follow Medicare status indicators. The payment amount will depend on the specialty as designated in 0800-02-18-.02(4) and 0800-02-18-.04(2).

(3) When a surgical fee is chargeable, no office visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination, in accord with Medicare guidelines. All exceptions require use of the appropriate modifiers.

(4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge, commonly known as a global fee. Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

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

Chapter 0800-02-18-.06 is amended by deleting the prior Rule 0800-02-18-.06 and replacing it with the following language, so that as amended the rule shall read:

0800-02-18-.06 Injection Guidelines

Reimbursement for injection(s) shall include CPT® code 96372 and appropriate "J" codes. Other surgery procedure codes defined as injections include the administration portion of payment for the medications billed. J Codes are found in the Health Care Financing Administration Common Procedure Coding System ("HCPCS"). Follow the Medicare guidelines in effect for the date of service for both single and multiple use vials of injectable medications for both medications and procedures. Immunization codes (vaccines and toxoid) should be reimbursed for both the medication and the procedure, reported separately with number of units administered.

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

Chapter 0800-02-18-.09 is amended by deleting the prior Rule 0800-02-18-.09 and replacing it with the following language, so that as amended the rule shall read:

0800-02-18-.09 Outpatient Physical, Speech, and Occupational Therapy Guidelines

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

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

(3) For physical therapy, occupational therapy, or speech therapy, there shall be no fee allowable for any modalities or therapeutic procedures performed in excess of four (4) modalities, therapeutic procedures, or combination thereof per type of therapy per day per employee, with no additional reductions such as those to the relative value units (RVUs). The definitions of modality and therapeutic procedures from the most recent American Medical Association's Current Procedural Terminology (CPT®) edition are applicable.

(4) For Functional Capacity Evaluations, the four- unit (time measurement) maximum may not apply if the documentation supports the extra units. The most recent CPT® codes available for Functional Capacity Evaluations are appropriate for use under the Tennessee Workers'

Compensation Medical Fee Schedule.

(5) Work Hardening/Conditioning Programs using the approved CPT® codes shall be billed at Usual and Customary hourly charges for a maximum of 6 hours per day or 60 hour maximum and are subject to utilization review prior approval. Payment is 80% of the billed charges.

(6) Whenever physical therapy, occupational therapy, or speech therapy services exceed twelve (12) visits, such treatment may be reviewed pursuant to the employer's utilization review program in accordance with the procedures set forth in Chapter 0800-02-06 of the Bureau's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the employer. Such certification shall be completed within the timeframes set forth in Chapter 0800-02-06 to assure no interruption occurs in the delivery of necessary services. Failure by a provider to properly certify such services as prescribed herein may result in the forfeiture of any payment for uncertified services. Failure by an employer or utilization review organization 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 or occupational therapy services or speech therapy shall, if necessary and appropriate, certify an appropriate number of visits. If necessary, further subsequent utilization review may be conducted to certify additional physical therapy, occupational therapy, or speech 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).

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: 12/4/2020

Signature: Abbie Hudgens

Name of Officer: Abbie Hudgens

Title of Officer: Administrator

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Tre Hargett

Tre Hargett
Secretary of State

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