

TENNESSEE'S WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

Introduction and Overview

The Tennessee Workers' Compensation Medical Fee Schedule Rules became effective July 1, 2005, pursuant to a mandate from the Tennessee General Assembly as part of the Tennessee Workers' Compensation Reform Act of 2004. See Tenn. Code Ann. § 50-6-204. The Medical Fee Schedule has undergone several revisions since the first version. This version of the Medical Fee Schedule became effective on February 25, 2018. The version effective at the time a medical service is or was rendered is the applicable one for that service. Use the previous version for dates of service prior to February 25, 2018 and this version for dates of service on or after February 25, 2018. (If the service spans February 25, 2018- (such as inpatient hospital care) then use this new version.)

The Medical Fee Schedule consists of three (3) parts, called chapters. The first chapter, Chapter 0800-02-17 (Rules for Medical Payments), contains specific information concerning impairment ratings, missed appointments, Independent Medical Evaluations (IMEs) and other general information applicable to the other two chapters. It contains the definitions used throughout all three chapters, as well as the purpose, scope, general guidelines and procedures. This chapter explains the basis for the Medical Fee Schedule, the time-period payers have to timely reimburse providers for undisputed bills, what happens if payers do not comply, and appeal procedures.

The second chapter, Chapter 0800-02-18 (Medical Fee Schedule), is the Medical Fee Schedule Rules for outpatient services and addresses the proper conversion factor and percentages to use for calculating the maximum allowable amounts for physicians' professional services, according to specialty and CPT® codes, the maximum allowable amounts that may be paid to other providers for durable medical equipment, prosthetics, orthotics, therapy services, drugs and other outpatient services provided to injured employees. Penalties, violations, and appeals are described.

Chapter 0800-02-19 (In-patient Hospital Fee Schedule) sets out in-patient reimbursements. The daily payments and the stop loss payments are not based on Medicare methods but reimburse hospitals on a per-day or "per diem" basis and include a method for extra payments for the most severe injuries. This chapter contains definitions and procedures specifically applicable to inpatient hospital reimbursements. Some Medicare definitions do apply.

These three (3) chapters of administrative rules listed above are referred to collectively as the Tennessee Workers' Compensation Medical Fee Schedule, the Medical Fee Schedule, and the Fee Schedule (MFS).

Additional Information about the Medical Fee Schedule

More information on the Medical Fee Schedule is available in the Medical Fee Schedule Rules, <http://publications.tnsosfiles.com/rules/0800/0800-02/0800-02.htm>, on the Bureau's webpage <https://www.tn.gov/workforce/injuries-at-work/bureau-services/bureau-services/medical-fee-schedule.html> or through the:

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I. DEFINITIONS AND REFERENCES

Most definitions needed for proper use of the Tennessee Medical Fee Schedule are provided in the Rules for Medical Payments, *See* Rule 0800-02-17-.03.

II. GENERAL INFORMATION AND OUTPATIENT

Tennessee's Medical Fee Schedule does not set an absolute fee for services, but instead, sets a maximum amount that may be paid. Providers and payers may negotiate amounts below the maximum set in the Medical Fee Schedule, but shall not pay an amount above the Fee Schedule maximum amount unless otherwise authorized by the Administrator. Time frames and penalties are listed in rules 0800-02-17-.13, 0800-02-18-.15, and 0800-02-19-.06.

The Medical Fee Schedule applies to ***all*** medical services and medical equipment or supplies.

Except when a waiver is granted by the Bureau, reimbursement to all providers ***shall be the lesser of:***

- (1) the provider's usual charge,
 - (2) the maximum fee schedule under these Rules, or
 - (3) the MCO/PPO or any other negotiated and contracted amount,
- See Rule 0800-02-18-.02

This lesser of comparison is done on the total bill or amount due, NOT a line-by-line comparison of items.

When there is no specific methodology in these Rules for reimbursement, the maximum reimbursement is 100% of the Medicare allowable amount in effect on the date of service. Medicare guidelines and procedures in effect at the date of service shall be followed in arriving at the correct amount. When there is no applicable Medicare code or method of reimbursement for the service, equipment, diagnostic procedure, etc. then the provider shall be reimbursed at 80% of the Usual & Customary charge. See Rule 0800-02-18-.02.

Procedure codes for unlisted procedures should only be used when there is no procedure code which accurately describes the services rendered. These codes require a written report and are paid at the allowable amount of the U&C charge (80% of billed charges.) See Rule 0800-02-17-.06.

Unless otherwise stated in the Rules, the applicable Medicare procedures and guidelines effective on the date of service are to be used. See Rule 0800-02-18-.02.

These Medical Fee Schedule Rules must be used in conjunction with the American Medical Association's CPT® Code guide, CMS, and 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 Anesthesiologist Relative Value Guide, the National Correct Coding Initiative Edits (NCCI) and Medicare procedures and guidelines (all in effect on the date of service) unless exempted in these rules. See Rule 0800-02-18-

.01

When extraordinary services resulting from severe head injuries, major burns, severe neurological injuries, or any injury requiring an extended period of intensive care, a fee may be allowed up to 150% of the professional service fees normally allowed under these Rules. This provision does not apply to In-patient Hospital facility fees. See Rule 0800-02-17-.10.

Adjustments to Bills

An employer's payment shall reflect any adjustments in the bill. An employer must provide an explanation of medical benefits to a health care provider whenever the employer's reimbursement differs from the amount billed by the provider.

Remittances for electronically submitted bills shall be in accordance with the Bureau's electronic billing. See Rules 0800-02-17-.10 and 0800-02-26.

Advanced Practice Nurses

See under Physician Assistants and Advanced Practice Nurses.

Ambulance Services

Pre-certification is required for all ground and air ambulance services that are non-emergency. Emergency ground and air ambulance services may be retrospectively reviewed. Reimbursement for these services is capped at the lesser of the submitted charges, or 150% of the current Medicare rate.

To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services. See Rule 0800-02-18-.13.

Anesthesia Services

Reimbursement for anesthesia services shall not exceed the maximum allowable of \$75.00 per unit. This is only applicable for anesthesia CPT® codes and does **NOT include** pain management services.

- (a) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, maximum reimbursement shall be **90%** of the maximum allowable fee for the anesthesiologist. No additional payment will be made to any physician supervising the CRNA.
- (b) Whenever anesthesia services are provided by an anesthesiologist or other physician and a CRNA, reimbursement shall never exceed 100% of the maximum

amount an anesthesiologist or physician would have been allowed under the Medical Fee Schedule Rules had the anesthesiologist or physician alone performed these services.

- (c) When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and post-operative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post anesthesia recovery area, except in appropriately documented extreme emergency situations. Total reimbursement for the nurse anesthetist and the anesthesiologist shall not exceed the maximum amount allowable under the Medical Fee Schedule Rules had the anesthesiologist alone performed the services. See Rule 0800-02-18-.05.

Case Manager Discussion

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 CPT® 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. See Rule 0800-02-17-.15.

Causation

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. See Rule 0800-02-17-.15.

Charges for Medical Reports

Consistent with the statute governing these transactions (T.C.A. § 50-6-204), a provider may charge up to \$10.00 for a medical report of twenty pages or less and charge \$0.25 per page for additional pages, so long as it is a complete medical report; this cost shall also apply to paper records transmitted on a disc or by other electronic means based upon the number of pages reproduced on the disc or other media. An office note or a

progress note from a follow-up visit is not considered a narrative report, and there can be no extra charge for submission of those documents.

No fee shall be paid if a request for medical records does not produce any records.

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). See Rules 0800-02-17-.15 and 0800-02-17-.16.

Chiropractic Services

Chiropractic services are capped at 130% of the Tennessee Adjusted Medicare allowable amount using the 33.9764 unit conversion factor. An office visit may only be billed on the same day as a manipulation when it is the patient's initial visit with that provider.

During the course of treatment, the chiropractor may bill a second E/M code if the patient does not adequately respond to the initial treatment regimen and a documented significant change is made in the treatment recommendations.

No payments are allowed for hot or cold packs, nor may a fee be charged for therapeutic procedures or modalities in excess of four (combined) per day. The Medicare definition of modality is applicable. See rule 0800-02-18-.08.

Clinical Psychological Services

Psychological treatment by any clinician other than a licensed psychiatrist is capped at 100% of the national Medicare allowable amount. Utilization review may be done whenever psychological treatment services exceed (12) visits. See Rule 0800-02-18-.14.

Depositions

The CPT® code **99075** must be used when billing for a deposition. The rate of maximum reimbursement for depositions is established in the Bureau's Rule 0800-2-16. Licensed physicians may charge their usual and customary fee for providing testimony by deposition to be used in a workers' compensation claim, provided that such fee does not exceed seven hundred fifty dollars (\$750) for the first hour. Depositions requiring over one (1) hour in duration shall be pro-rated at the licensed physician's usual and customary fee as set forth above, not to exceed four hundred fifty dollars (\$450) per hour for deposition time in excess of one (1) hour. Physicians shall not charge for the first quarter hour of preparation time. In instances requiring over one quarter hour of preparation time, a physician's preparation time in excess of one quarter hour shall be added to and included in the deposition time and billed at the same rates as for the deposition.

The fee for appearance in person as a witness should be negotiated and agreed to in advance. *See* Rules 0800-02-16-.01 and 0800-02-17-.17.

Dentistry

Dental services using ADA dental codes are capped at 100% of the Tennessee Adjusted Medicare amount. If there is no appropriate Medicare amount (in many instances), then the maximum amount allowed under the Medical Fee Schedule is usual and customary, which is 80% of the billed charges.

Oral surgery follows the surgery percentage when using CPT® codes. *See* Rule 0800-02-18-.02.

Disputes Regarding Reimbursement

Unresolved disputes between an employer and provider concerning bills due to conflicting interpretation of these Rules and/or the Medical Fee Schedule Rules and/or the In-patient Hospital Fee Schedule Rules may be submitted to the Medical Payment Committee (the Committee-MPC) in accordance with the provisions in T.C.A. § 50-6-125. A request for Committee Review may be submitted on the form posted by the Bureau within one (1) year of the date of service to: Medical Director of the Bureau of Workers' Compensation, Tennessee Department of Labor and Workforce Development, Suite 1-B, 220 French Landing Drive, Nashville, Tennessee 37243, or any subsequent address as prescribed by the Bureau.

If the request for review does not contain proper documentation including the required C-47 form, then the MPC may decline to review the dispute. Likewise, if the timeframe is not met, then the MPC may decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

If the parties to the dispute do not follow the decision of the MPC, then either party may proceed in the court of law with proper jurisdiction to decide the matter. *See* Rule 0800-02-17-.21.

Durable Medical Equipment, Medical Supplies and Implant Reimbursement

Durable medical equipment ("DME") and medical supplies, including home DME, infusion and oxygen services, other than implantables, shall be reimbursed at the lesser of the billed charges or 100% of the applicable Medicare allowable amount.

Durable medical equipment and supplies billed at \$100.00 or less for which there is no applicable Medicare allowable amount shall be limited to (80%) of billed charges; those that are billed in excess of \$100.00 with no Medicare Allowable amount are each reimbursed at the manufacturer's invoice amount plus 15% of invoice amount with the 15% capped at \$1,000.

Implants for which billed charges are \$100.00 or less are capped at 80% of those charges. For implants which exceed \$100.00, the maximum allowable is the manufacturers' invoice amount plus 15% of invoice, with the 15% capped at a maximum of \$1,000. This calculation is per item and is not cumulative. No extra payment shall be made for implants provided as part of hospital outpatient or ASC services if according to CMS regulations and status indicators, they are included in the APC payment. Consult Rule 0800-02-18-.07 for specifics.

Continuous Passive Motion (CPM) and Other External Exercise/Treatment Devices used in excess of the days recommended by the Bureau's adopted treatment guidelines requires documentation of medical necessity by the doctor.

The use of cold compression therapy units and other external exercise/treatment devices in excess of 7 days (or the length of use recommended by the Bureau's adopted treatment guidelines) requires documentation of the device's use and medical necessity and may be subject to utilization review. See Rules 0800-02-18-.07 and 0800-02-18-.10.

Hearing Aids

Hearing Aids are considered orthotics. Refer to orthotics for payment.

Home Health Services

Home Health Services (episodic; and not "LUPA" adjustment) are capped at 100% of Medicare. See Rule 0800-02-18-.02.

Independent Medical Examination

Independent Medical Examination (“IME”) refers to an examination and evaluation conducted by a practitioner different from the practitioner providing care, other than one conducted under the Bureau’s Medical Impairment Rating Registry Program (MIRR). An IME shall be billed at \$500.00 per hour and pro-rated per half hour. Physicians may only require a pre-payment of \$500.00 for an IME. Following completion of the IME and report, the physician may bill for other amounts appropriately due. The office visit billed is included with the CPT® code **99456** and shall not be billed separately. Lab, x-rays, or other tests shall be identified and reimbursed separately according to proper coding.

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® code **99358** for the first hour and CPT® code **99359** for each additional hour. 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 may not exceed \$500.00. *See* Rule 0800-02-17-.09.

Injection Guidelines

Reimbursement for injection(s) (such as J codes) includes allowance for CPT® code **96372**. 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 and reported separately with number of units administered. *See* Rule 0800-02-18-.06.

Impairment Rating and Evaluations

This applies to all workers’ compensation claims with initial dates of service on or after January 8, 2009 but does not apply to IMEs.

A treating physician who determines the employee’s maximum medical improvement date for the distinct injury he/she is treating shall also determine the impairment rating.

A treating physician is defined in these rules as:

1. a physician chosen from the panel required by T.C.A. Section 50-6-204;
2. a physician referred to by the physician chosen from the panel required by T.C.A.

Section 50-6-204;

3. a physician recognized and authorized by the employer to treat an injured employee for a work-related injury; or
4. a physician designated by the Bureau to treat an injured employee for a work-related injury.

Within 21 calendar days of the date the treating physician determines the employee has reached maximum medical improvement, the treating physician shall submit to the employer or carrier, as applicable, a fully completed report on a form prescribed by the Administrator.

The employer or carrier, as applicable, shall submit a fully completed form C-30A to the Bureau and the parties within 30 calendar days of the date they receive a request from the Bureau.

Upon determination of the employee's impairment rating, the treating physician shall enter the employee's impairment rating into the employee's medical records. In a response to a request for medical records pursuant to T.CA Section 50-6-204, a provider, treating physician or hospital shall include the portion of the medical records that contains the impairment rating.

The authorized treating physician shall receive reimbursement of **no more than \$250.00**. For payment, the charge (CPT® code **99455** and an explanation) must be submitted to the appropriate insurance company, third party administrator or employer. The payment shall only be made to the authorized treating physician. The authorized treating physician shall not require prepayment of such fee. Failure to fully complete the form and submit it within the appropriate time frames shall subject the employer or authorized treating physician as applicable to a civil penalty of \$100 for every 15 calendar days passed the required date until the fully completed form is received by the Bureau (if requested). See Rule 0800-02-17-.25.

Laboratory/Pathology Services

Laboratory rates are paid at the pathology percentage of 200%. Hospital outpatient services are based on 200% of Medicare's the national clinical lab schedule. Laboratory rates for non-hospital settings are based on 200% of the Tennessee clinical lab schedule.

Post-injury drug screens must be paid in accordance with the Medical Fee Schedule Rules. Drug screens not related to a workers' compensation injury, such as pre-employment screening, are not subject to the Fee Schedule Rules.

For free standing or in-office laboratory, pathology and toxicology procedures including urine drug screens (UDS), these services shall be reimbursed at the pathology percentage

when there is a G code or applicable cross-walk CPT® code. For any urine drug screens, the laboratory requisition must specify exactly which drugs are to be tested and why. The billing code(s) submitted shall be those recognized by Medicare as appropriate for the date of service. The frequency of urine drug screens should be in accord with the most recent version of the Department of Health Tennessee Chronic Pain Guidelines, Clinical Practice Guidelines for the Outpatient Management of Chronic Non-Malignant Pain. See Rule 0800-02-18-.02.

Medicare Maximum Allowable Reimbursements

Unless otherwise indicated, for these Rules, the Medicare procedures and guidelines are effective upon adoption and implementation by the CMS. The particular procedure or guideline to be used is that which is in effect on the date the service is rendered. Whenever there is no specific fee or methodology for reimbursement in the Medical Fee Schedule Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the effective CMS' Medicare allowable amount in effect on the date of service.

This provision does not apply to the Medicare conversion factor. The conversion factor for the state of Tennessee, which is 33.9764, shall be used in conjunction with the most current Medicare RVU's. See Rule 0800-02-18.02.

Missed Appointments

If an appointment is scheduled by the employer, carrier, or a case manager representing a carrier or employer, a provider may charge up to the amount of the basic office visit amount for a missed appointment. This amount shall not include any bill for diagnostic testing that would have been billed. Missed appointments should be billed with the **99199** CPT® code, but an explanation of what would have been done with appropriate CPT® codes should accompany the bill. See Rule 0800-02-17-.14.

Modifiers

Modifiers listed in the most current CPT® shall be added to the procedure code when the service or procedure has been altered from the basic procedure explained by the descriptor. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. When **Modifier -21, -22, or -25** is used, a report explaining the medical necessity must be submitted to the employer. The maximum allowable for **Modifier -22** is 50%, not to exceed billed charges of the primary procedure. **Modifier -22**, in accordance with Medicare principles, should only be used when a case is clearly out of the range of ordinary difficulty for that type of procedure.

Orthopaedic surgeons and neurosurgeons may use the **modifier "ON"** on the appropriate billing form, when submitting surgical charges. See Rules 0800-02-18-.02 and 0800-02-17-.07.

Orthotics and Prosthetics

Payment shall be 115% of the Tennessee Medicare allowable amount. If the invoice amount exceeds the Medicare payment at the time of delivery, the payment shall be the higher of the invoice amount or 115% of the Medicare allowable amount. Charges for these items are in addition to, and shall be billed separately from all other facility and professional service fees. Supplies and equipment should be coded with CPT® code **99070** if appropriate codes are not available and the maximum reimbursement shall be the usual and customary amount. Fitting and customizing codes may be reimbursed separately according to Medicare guidelines. See Rule 0800-02-18-.11.

Out-of-State Medical Services

Providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Worker's Compensation Act 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. See Rule 0800-02-17-.18.

Outpatient Services (Including Emergency Room Care if Patient is Not Admitted)

All services paid under the OPPS are classified into groups called Ambulatory Payment Classifications (APC). Services in each APC are similar clinically and in terms of the resources they require. The CMS has established a payment rate for each APC. Current APC Medicare allowable payment amounts and guidelines are available online at: <http://www.cms.hhs.gov/HospitalOutpatientPPS>. The payment rate for each APC group is the basis for determining the maximum total payment to which an Ambulatory Surgery Center (ASC) or hospital outpatient center is entitled, including add-ons, hospital outpatient procedures, multiple procedure discounts and status indicators, according to current CMS guidelines effective on the date of service.

Under the Medical Fee Schedule Rules, the OPPS reimbursement system shall be used for reimbursement for all outpatient services, wherever they are performed, in a free-standing ASC or hospital setting. The most current, effective Medicare APC rates shall be used as the basis for facility fees charged for outpatient services and shall be reimbursed at a maximum of 150% of current value for such services. Depending on the services provided, ASCs and hospitals may be paid for more than one APC for an encounter. When multiple surgical procedures are performed during the same surgical session, Medicare guidelines

in effect on the date of service shall be used in determining separate and distinct surgical procedures and the order of payment. If a claim contains services that result in an APC payment but also contains packaged services, separate payment of the packaged services is not made since the payment is included in the APC.

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

All other outpatient hospital care in all ASCs and all hospitals (including but not limited to observation and emergency room), facility fees shall be calculated in accordance with the most current Medicare rules and procedures applicable to such services and shall be reimbursed at a maximum rate of 150% of the current value of Medicare reimbursement for outpatient hospital care.

For cases involving implantation of medical devices (implantables), regardless of the current Medicare status indicators, payment shall be made only to the facility.

Technical components for radiology when done in an ASC or hospital outpatient will be paid at 150% of Medicare, but may only be broken out when the Medicare APC code does not include it.

All hospitals with ambulatory patients who stay longer than 23 hours past ambulatory surgery or other diagnostic procedures and are formally admitted to the hospital as an inpatient will be paid according to the In-patient Hospital Fee Schedule Rules. Medicare hospital criteria shall apply to these cases. See Rule 0800-02-18-.07.

Pattern of Practice

Pattern of Practice means repeated, similar violations over a three-year period of the Medical Fee Schedule Rules. See Rule 0800-02-17-.03.

Payment

Employers (see definition that includes bill reviewers and payers at T.C.A. § 50-6-102 and Rule 0800-02-17-.03) shall provide an explanation of medical benefits with current and complete contact information to the health care provider whenever the reimbursement differs from the amount billed. An employer must date-stamp medical bills and reports not submitted electronically upon receipt. Payment for all properly submitted and complete bills not disputed within 15 business days (or uncontested portions of the bill) shall be

made to the provider within 30 calendar days. If the bill was not properly submitted, the employer must notify the provider and specify the reason(s) within 15 business days of receipt of the bill.

Any provider not receiving the undisputed portion of the provider's bill may institute a collection action in a court having the proper jurisdiction over such matters to obtain payment of the bill. Such providers, if they prevail, shall also be entitled to reasonable costs and attorney fees incurred in such collection actions to be paid by the employer.

Providers **shall not** attempt to collect the balance of a bill from the injured employee. See Rule 0800-02-17-10.

Pharmacy

Prescribed drugs are capped at the lesser of:

- 1) the provider's usual charge,
- 2) the average wholesale price (AWP) (only the original manufacturer's NDC number should be used in determining AWP) plus a \$5.10 filling fee, or
- 3) a negotiated contractual amount that is less than or equal to the above reimbursements under the Fee Schedule.

Physicians dispensing drugs from their office do not receive the additional \$5.10 filling fee.

All pharmaceutical bills submitted for repackaged or compounded products must include the NDC Number of the original manufacturer registered with the U.S. Food & Drug Administration or its authorized distributor's stock package used in the repackaging or compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the product or ingredient, calculated on a per unit basis, as of the date of dispensing. A repackaged or compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If the original manufacturer's NDC Number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis.

A compounding fee no higher than \$25.00 is allowed per compound prescription if two or more prescriptive drugs require compound preparation when sold by a hospital or pharmacy.

Generally, an injured employee should receive only generic drugs or single-source patented drugs for which there is no generic equivalent unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription "dispense as written" or "no substitution allowed" in the prescriber's own handwriting.

Should an injured employee wish to receive brand name drugs when a generic is available and allowed by the physician, she or he may do so at their own expense.

Pharmacists must bill and be reimbursed their usual retail price for over-the-counter non-prescription drugs. No Filling Fee is allowed for these non-prescription drugs. See Rule 0800-02-18-.12.

Physical Therapy/Occupational Therapy (PT/OT)

Reimbursement for physical and occupational visits shall not exceed 130% of the Tennessee adjusted Medicare allowable amount, no matter where the services are performed- see home health services as an exception.

There shall be no payment allowed for any modalities or therapeutic procedures performed in excess of 4 per day per employee. This maximum includes combinations. No additional reductions for relative value units (RVUs) should be applied.

For Functional Capacity Evaluations (FCE's) the four unit (time measurement) maximum may not apply as long as the documentation supports the extra units.

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.

Physical or occupational therapy services in excess of 12 visits may be reviewed pursuant to the employer's utilization review program. In order to facilitate expedited utilization review, whenever a physician orders PT or OT, the physician should include the diagnosis on the prescription for PT or OT. See Rule 0800-02-18-.09.

Physician Assistants and Advance Practice Nurses Reimbursement for Surgery

Appropriately licensed physician assistants and advance practice nurses may serve as surgical assistants but shall be limited in reimbursement to the fee due under Medicare guidelines, without regard to conversion factors or percentages applied to their supervising physician specialty.

The need for a surgical assistant, assisting surgeon, co-surgeon, second surgeon or team surgery will follow Medicare status indicators.

Physician Assistant and Advance Practice Nurse's Reimbursement in Office and Other Settings:

The Evaluation and Management additional percentage is not applicable to PA and NP charges. Their reimbursement shall be paid at the standard Medicare rate. See Rule 0800-02-18-.04.

Physician Office Visits

All physicians' office visits are paid up to a maximum of 160% of the Tennessee Medicare amount which should be calculated based on the conversion factor of 33.9764 rather than the current Medicare conversion factor, regardless of the physician's specialty. This percentage is not applicable to PA and NP charges, which shall be paid at the standard Medicare rates. See Rule 0800-02-18-.02- Evaluation and Management (E&M).

Preauthorization

Preauthorization means that the employer, prospectively, or concurrently authorize the payment of medical benefits. Preauthorization for workers' compensation claims does not mean 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.

Preauthorization is required for all non-emergency medical services (outpatient and inpatient). Failure to timely communicate (within 7 working days) the decision of authorizing or not authorizing the service requested by a medical provider shall result in the authorization being deemed approved. See Rule 0800-02-17-.03

Presumptive Authorization

If a provider makes a written request by fax or e-mail (and receives acknowledgement of receipt of the request) for authorization for a treatment at least 21 business days in advance of the anticipated date that treatment is to be delivered and has not been notified of a denial or modification in writing or confirmed telephone call or confirmed fax at least 7 business days in advance of the date of the proposed treatment, it is presumed to be medically necessary, a covered service, and to be paid for by the employer. If a provider makes a verbal request for authorization, the burden of proof for showing that authorization was granted by the employer rests with the provider. See Rule 0800-02-17-.19.

Professional Services

The Centers for Medicare and Medicaid Services (CMS) has eliminated the use of all inpatient and office/outpatient consultation codes for dates of service on or after January 1, 2010. In-patient codes **99251** to **99255** and outpatient/office codes **99241** to **99245** will no longer be accepted by CMS. As a result, medical providers who are billing under the Tennessee Medical Fee Schedule, which is largely based on Medicare's reimbursement formula, will need to discontinue the use of inpatient codes **99251** to **99255** and outpatient/office codes **99241** to **99245**. Instead, medical providers should bill, as applicable:

- Initial inpatient hospital care: **99221** to **99223**
- Subsequent hospital care: **99231** to **99233**
- Initial nursing facility care: **99304** to **99306**
- New patient office visit: **99201** to **99205**
- Established patient office visit: **99211** to **99215**

The official instruction issued by CMS can be found at:

<http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf>

Pursuant to a rule amendment that became effective on August 9, 2012, practitioner fees shall be based on the conversion factor of **33.9764**, which shall be used in conjunction with the most current Medicare RVUs for all dates of service on or after August 9, 2012. The following Tennessee specific conversion percentages should be applied to the service category in order to calculate the appropriate amount.

Service Category	TN Specific Conversion Percentage
Orthopaedics and Neurosurgery	275%
General Surgery	200%
Radiology	200%
Pathology	200%
Physical/Occupational Therapy	130%
Chiropractic	130%

General Medicine (including Evaluation & Management- E&M)	160%
Emergency Care	200%
Dentistry	100%
Anesthesiology	75.00 per unit

Maximum allowable fees for professional services should always be calculated by multiplying the current Medicare Tennessee adjusted RVU's with Geographic Practice Cost Index (GPCI's). The sum of those products is multiplied with the Tennessee conversion factor of 33.9674. Then the appropriate Tennessee conversion percentage of that amount for that type of code and provider should be applied. The Medicare RVU's and GPCI's used in the following examples are current through February 25, 2018.

Example

CPT® code **99204** --- Office/outpatient visit, new patient: The maximum allowable for Tennessee is 235.58 (160 % of TN Medicare based on the conversion factor of 33.9764). This is calculated by the following:

$$(\text{work RVU } 2.43 \times \text{work GPCI } 1.000) = 2.430 + (\text{transitioned non-facility PE RVU } 1.99 \times \text{PE GPCI } 0.901) = 1.79299 + (\text{MP RVU } 0.21 \times \text{MP GPCI } 0.526) = 0.11046 = 4.33345$$

$$\text{Total RVU's} = 4.33345 \times \text{TN conversion factor } 33.9764 = 147.2350305 \times 1.6 \text{ for E\&M} = 235.58$$

Example

CPT® code **25444** ---Reconstruct wrist joint; The maximum allowable for surgeons other than Orthopaedic and Neurosurgeon for Tennessee is 1473.85 (200% of TN Medicare based on the conversion factor of 33.9764).

For orthopaedic and neurosurgeons, the maximum allowable for Tennessee is 2026.54 (275% of TN Medicare based on the conversion factor of 33.9764). This is calculated by the following:

$$(\text{work RVU } 11.42 \times \text{work GPCI } 1.000) = 11.42 + (\text{transitioned facility PE RVU } 10.09 \times \text{PE GPCI } 0.901) = 9.09109 + (\text{MP RVU } 2.24 \times \text{MP GPCI } 0.526) = 1.17824 = 21.68933$$

$$\text{Total RVU's} = 21.68933 \times \text{TN conversion factor } 33.9764 = 736.9253518 \times 2.0 \text{ Surgery} = 1473.85$$

$$\text{Total RVU's} = 21.68933 \times \text{TN conversion factor } 33.9764 = 736.9253518 \times 2.75 \text{ Orth/Neuro Surgeon} = 2026.54$$

See Rule 0800-02-18-.02.

Providing Behavioral Intervention or Counseling

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** (or CPT® codes **96150-96155**, if appropriate) 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. *See Rule 0800-02-17-.15.*

Radiology Services

Non-ASC, non-hospital radiology (those done in a physician's office) may be reimbursed up to a maximum of 200% of the Tennessee Adjusted Medicare amount using the 33.9764 unit conversion factor for both the technical and professional fees. This includes Diagnostic Facilities and Urgent Care Facilities. *See Rule 0800-02-18-.02.*

Surgery, Surgical Assistants and Modifiers

Physicians performing surgery may generally receive up to 200% of the allowable Tennessee Adjusted Medicare amount (based on the conversion factor of 33.9764). Orthopaedic Surgeons and Neurosurgeons may receive up to 275% of the Tennessee adjusted Medicare amount for surgical services only.

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.

A physician who assists at surgery may be reimbursed up to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount. *See Rule 0800-02-18-.04.*

Telehealth

The definitions, licensing and processes for the purpose of these rules shall be the same as adopted by the Tennessee Department of Health. Payments shall be based upon the applicable Medicare guidelines and coding for the different service providers with the exception of any geographic restriction. The Tennessee specific conversion factor and the Tennessee specific percentages do apply. *See Rule 0800-02-17-.05.*

The Tennessee Medical Fee Schedule is a "Cap"

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. Any provider accepting and any employer paying an amount in excess of the fee schedule shall be in violation of the Rules and may at the Administrator's discretion be subject to civil penalties. See Rule 0800-02-17-.10.

Timely Filing

Timely filing of bills for medical services means the period of time within which a provider must request payment consistent with Medicare time limits. See Rule 0800-02-17-.03.

Utilization Review

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. See Rule 0800-02-17-.03.

III. IN-PATIENT HOSPITAL FEE SCHEDULE

Amounts in Addition to Per Diem Charges

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 applicable /HCPCS codes.

Durable Medical Equipment --- Reimbursement for durable medical equipment and for which billed charges:

- (a) Are \$100.00 or less shall be limited to 80% of billed charges;
- (b) Exceed \$100.00 shall be reimbursed at a maximum amount of the supplier or manufacturer's invoice amount, plus the lesser of 15% of invoice amount or \$1,000.00. These calculations are per item and are not cumulative. Charges for durable medical equipment are in addition to, and shall be billed separately from, all facility and professional service fees.
- (c) This Rule shall not apply to durable medical equipment and medical supplies with applicable Medicare allowable amounts. Such durable medical equipment and medical supplies shall be reimbursed at the lesser of the billed charges or 100% of the applicable Medicare allowable amount.

Orthotics and Prosthetics ---

Orthotics and prosthetics, not supplied under Rule 0800-02-18-.07, should be coded according to the HCFA Common Procedures Coding System (HCPCS). Payment shall be 115% of Tennessee Medicare allowable amount. If the invoice amounts exceed the Medicare payments amounts at the time of delivery, the payment for orthotics and prosthetics shall be the higher of invoice amounts or 115% of the Tennessee Medicare allowable amount and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from all other facility and professional service fees.

Implantables ---

Reimbursement is limited to the invoice amount plus 15% -of the invoice amount with the 15% capped at \$1,000. This is applicable per item not cumulative.

Take-home Medications and Medical Supplies ---

All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines in Rule 0800-02-18-.12. Take home medical supplies shall be reimbursed pursuant to current Medicare guidelines up to 100% of the Medicare allowable amount.

The above-listed items are reimbursed in accordance with the Rules for Medical Payment (Chapter 0800-02-17) and Medical Fee Schedule Rules (Chapter 0800-02-18) payment limits. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-02-17-.03 unless otherwise indicated in the Medical Fee Schedule Rules. In-patient hospital *per diem* rates are all inclusive (with the exception of those items listed above).

In-patient Hospital Services Are Reimbursed under a Per Day Methodology

In-patient services are calculated under a per day or "*per diem*" basis, not under the Medicare Diagnosis Related Group (MS-DRG) system. This is one of the areas in which the Tennessee Medical Fee Schedule differs from the Medicare basis used throughout most of the Fee Schedule Rules.

Except when a waiver is granted by the Bureau, reimbursement for a compensable workers' compensation claim **shall be the lesser of**

1) the hospital's usual charges.

2) the PPO or other contracted amount, or

3) the maximum amount allowed under this In-patient Hospital Fee Schedule.

Groupings

In-patient hospitals are grouped into the following separate peer groupings:

1. Peer Group 1: Licensed Hospitals
2. Peer Group 2: Licensed Rehabilitation Hospitals
3. Peer Group 3: Licensed Psychiatric Hospitals
4. Peer Group 4: Licensed Level 1 Trauma Centers

See Rules 0800-02-19-.03 and 0800-2-19-.01.

Maximum Allowable Reimbursement Amounts

The maximum *per-diem* rates to be used in calculating the reimbursement rate is as follows (based upon the assigned MS-DRG):

Surgical Admissions - \$2,235.00 for the first 7 days; \$1,935.00 per day for each day thereafter. This includes Intensive Care (ICU) & Critical Care (CCU) if not a trauma admission.

Medical Admissions - \$1,840.00 for the first 7 days; \$1,590.00 per day for each day thereafter.

Rehabilitation Hospitals - \$1,090.00 for the first 7 days; \$890.00 per day for each day thereafter.

Psychiatric Hospitals (applicable to chemical dependency as well) maximum allowable amount is \$790.00 per day.

Trauma Level 1 All trauma care at any licensed Level 1 Trauma Center only shall be reimbursed at a maximum rate of \$4,500.00 per day.

See Rule 0800-02-19-.03.

Non-covered charges

Non-covered items are: convenience items, charges for services not related to the work injury/illness services.

Pharmacy Services

Pharmaceutical services rendered as part of in-patient care are considered inclusive within the In-patient Hospital Fee Schedule and shall not be reimbursed separately. See Rule 0800-02-19-.05.

Pre-admission Utilization Review

Prospective utilization review is required for non-emergent, non-urgent in-patient services. Emergency or urgent admissions require utilization review to begin within one (1) business day of the employer receiving notification of the admission. If the duration of the inpatient stay is longer than the number of days certified by pre-admission review, then the payer shall implement concurrent review until discharge. For emergency inpatient admissions, the payer shall begin retrospective review within 1 business day of notice of the admission. The timeframes and other requirements of Chapter 0800-02-06 shall apply to all utilization review. See Rule 0800-02-19-.04.

Reimbursement Calculations Explanation:

1. Each admission is assigned an appropriate MS-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.
Reimbursement Formula: LOS X SPDA = WCRA

Example: DRG: 470 Knee Procedures W/O CC
Hospital Peer Group: 1-Surgical admission:
Total Billed Charges:\$40,000.00
Maximum rate per day: \$2,235 first seven (7) days/\$1,935 per day each day thereafter
Number billed days: 3
Billed charges (after subtracting amounts for implants,)..... \$25,000.00
Maximum allowable payment for normal DRG stay.....\$6,705.00
Amounts due hospital for implants\$2,500.00
Maximum fee schedule amount\$6,705.00 + \$2,500.00 = \$9,205.00

Proper reimbursement would be the lesser of billed charges, maximum fee schedule amount, or other contracted or negotiated rate. See Rule 0800-02-19-.03.

Stop-Loss Method

Stop-loss is an independent reimbursement factor established to ensure reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

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 \$20,750.00 for Non-Trauma Admissions and \$30,000.00 for Trauma Admissions. Amounts for items set forth in Rule 0800-02-19-.03(2)(e)(4) such as implantable, DME, orthotics and prosthetics, ambulance services, and take home medicines **shall NOT be included in determining the total allowed charges for stop-loss calculations.**

This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission. 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%. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

The stop-loss formula: (Additional Charges x SLRF) + Maximum Allowable Payment = WCRA

Example: DRG: 470 Knee Procedures W/ CC

Hospital Peer Group: 1-Surgical admission:

Maximum rate per day: \$2,235 first seven (7) days/\$1,935 per day each day thereafter

Number billed days: 9

Total Billed Charges\$120,000.00

Billed charges (after subtracting the amount for implants).....\$100,000.00

Maximum allowable payment for normal MS DRG stay:.....\$19,515.00

Total difference, charges over and above maximum payments.....\$80,485.00

(If this amount is \$20,750.00 or less for non-trauma, then stop loss is not applicable.)

Difference over and above \$20,750.00 stop-loss is.....\$59,735.00

Payable under stop-loss (80% of \$59,735.00).....\$47,788.00

Amounts due hospital for implants\$5,000.00

Maximum fee schedule amount:.....19,515.00 + 47,788.00 + 5,000 = \$72,303.00

Proper reimbursement would be the lesser of billed charges, maximum fee schedule amount, or other contracted or negotiated rate. See Rule 0800-02-19-.03.

Trauma care

"Trauma Admission" means:

(a) Any level 1 trauma center hospital admission in which the patient has an ICD-9 diagnosis code of 800 to 959.99, or ICD-10 code that is (or includes) S00.OOXA through S99.99XX, T07, T14 to T32, T79 and the claim includes an ICU revenue code of 020x or a CCU revenue code of 021x, or

(b) Any level 1 trauma center hospital admission for any diagnosis with a trauma response revenue code of 068x and/or type of admission code, "5."

Note: this includes all hospital days that qualify as an inpatient day as defined under inpatient services.

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. See Rule 0800-02-19-.03.

A list of all trauma centers in the state may be accessed at this website:
<https://www.tn.gov/health/health-program-areas/health-professional-boards/ems-board/ems-board/trauma-centers.html>