Tennessee Workers' Compensation **Medical Fee Schedule**

Handbook

Effective April 1, 2026, through March 31, 2027

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 Handbook, the rate tables, and the 2026 Medicare updates became effective on April 1, 2026, including the calculation examples listed on page 22.

The values listed in the calculations are used for the purpose of providing examples.

Please refer to the Bureau rules that became effective September 25, 2023 for specific information and instructions for use with the rate tables (0800-02-17, Rules for Medical Payments; 0800-02-18, Medical Fee Schedule; and , 0800-02-19, Inpatient Hospital Fee Schedule).

From April 1, 2026 until March 31, 2027, refer to the **Rate Tables**. These Tables can be accessed free of charge in a digital and downloadable format from the FAIR Health orders site: Fair Health Online Product Orders.

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 within which payers shall 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 applicable Tennessee state specific percentages used to create the maximum allowable fees in the rate tables for physicians' professional services, according to specialty and Current Procedural Terminology (CPT®) codes, 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, or 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, Rules of the Tennessee Department of Labor and Workforce Development on the Bureau's webpage Medical Fee Schedule or through the:

Bureau of Workers' Compensation
220 French Landing Drive, Suite 1-B Nashville, TN 37243
Telephone: (615) 532-1325

Electronic Mail: wc.mpc@tn.gov

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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 may charge less, and payers and providers may negotiate amounts below the maximum set in the Medical Fee Schedule but shall not pay an amount above the Fee Schedule maximum amount found in the rate tables (with the addition of the amounts specified for applicable modifiers) 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***:

a. the provider's usual charge,

b. the fee listed in the rate tables, after applying any applicable modifiers, methodologies, or exceptions set forth in these Rules (Chapter 0800-02-17, Chapter 0800-02-18, or Chapter 0800-02-19); or 100% of the Medicare rate if the code is not listed in the rate tables, or the methodology is not set forth in these Rules,

c. a signed MCO/PPO agreement or any other negotiated and contracted amount below the maximum allowable. 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 no fee exists in the rate table and 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 on April 1, 2026 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 (U&C) charge. See Rule 0800-02-18-.02 and Rule 0800-02-17-.03.

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.

Where codes or other reports are listed with a dollar amount in these Rules, conversion to RVUs may be calculated by dividing the applicable dollar amount by the National Medicare Conversion Factor of $33.4009 from April 1, 2026, through March 31, 2027. The Tennessee Specific Conversion Percentages are not applied to these codes or charges. See Rule 0800-02-17-.06.

Unless otherwise stated, the applicable Medicare procedures and guidelines effective on April 1, 2026, are to be used. Any Medicare quarterly or other updates shall not be applied. See Rule 0800-02-18-.02.

These Medical Fee Schedule Rules must be used in conjunction with the American Medical Association (AMA) CPT® Code guide, American Dental Association codes, Centers for Medicare & Medicaid Services (CMS), and procedure coding system Healthcare 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 Anesthesiologist Relative Value Guide, the National Correct Coding Initiative Edits (NCCI) and Medicare procedures and guidelines. For Medicare guidelines until December 31, 2023, follow those in effect for the dates of service. For dates of service between January 1, 2024, and March 31, 2024, follow Medicare guidelines in effect for December 31, 2023. For all services on and after April 1, 2024, through March 31, 2025, follow the applicable rate table. See Rule 0800-02-18. For all services on or after April 1, 2025, through March 31, 2026, follow the applicable rate table. For all services on or after April 1, 2026, through March 31, 2027, follow the applicable rate table.

Note that Medicare rules in effect on April 1, 2026, will be used throughout the period from April 1, 2026, through March 31, 2027.

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 with current and complete contact information to a health care provider whenever the employer's reimbursement differs from the amount billed by the provider. Industry standard remark codes and a clear reason for the adjustment shall be provided. Any delayed or non-payment of properly submitted bills shall be communicated to the provider according to Chapter 0800-02-14 and provide appropriate explanation and contact information. See Rule 0800-02-17-.10. 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 ground services are capped at the lesser of the submitted charges or the rate listed in the rate table (based on 150% of Medicare). The rates determined in the rate tables shall not apply to air ambulance services as defined by federal law.

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 Certified Registered Nurse Anesthetist (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.

Each anesthesia service contains two components which make up the charge and determine reimbursement: a Base Unit and a Time Unit. The maximum number of base units are listed in the rate table. If a discrepancy exists between the American Society of Anesthesiologists (ASA) base units and the CMS base units, use the CMS units and not the base units in the rate tables. Physical status modifiers and qualifying circumstance codes may be appropriately added according to Medicare guidelines in effect on the date of service. Each 15 minutes equals (1) Time Unit. An additional unit shall be billed when an additional 1-15 minutes of anesthesia has elapsed.

Anesthesia by a Surgeon

Local Anesthesia: When infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgeon's assistant, reimbursement for the procedure and anesthesia are included in the global reimbursement for the procedure. Regional or General Anesthesia: When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, payment is included in the surgical procedure reimbursement listed in the rate tables. Applicable Medicare procedures and guidelines in effect April 1, 2026, are to be used.

Unlisted Service, Procedure or Base Unit

When an unlisted service or procedure is provided or a Base Unit is not listed in the rate tables, the value per unit used shall be substantiated by report.

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 on the same day as an office visit charge provided the extra time is equal to or greater than fifteen (15) minutes. State-specific code **Z0410** shall be used for thirty (30) minutes or less ($40 for 15-30 minutes). State-specific code **Z0411** shall be used for greater than thirty (30) minutes ($80 for 31 minutes or greater). The physician may charge for consultation with a case manager using the appropriate consultation or team conference CPT® code, when not on the same day as an office visit.

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 charged by the physician and paid by the requesting party using state-specific code **Z0210** ($200 for one hour or less) and state-specific code **Z0211** ($100 for each additional 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.

Certified Physician Program in Workers' Compensation (CPP)

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

a) Initial Assessment (billed as an additional code **Z0815**) $80

b) Subsequent visit (billed as an additional code **Z0816**)....................$40

c) Assessment of Permanent Impairment and timely completion of the Final Medical Report (C30-A) (billed as an additional code **Z0817**)....................$100

For example, a CPP doctor may bill the appropriate CPT® code for the initial assessment and the Z0815 on the same day. A CPP doctor may bill a subsequent visit CPT® and the Z0816 on the same day.

If the CPP doctor believes in good faith that the employee retains permanent impairment upon reaching maximum medical improvement, the CPP doctor may bill Z0310 and Z0817 on the same day. If that is the same day of the subsequent visit, the CPP doctor may bill the appropriate CPT® code for the subsequent visit and **Z0816, Z0310, Z0817** on the same day. **Z0815** and **Z0816** are payable for appropriate E/M codes, **Z0817** is payable in conjunction with **Z0310**. These fees may be subject to contract negotiations, shall not be billed in the applicable Medicare "global period" and shall only be used for Tennessee jurisdictional claims. See Rule 0800-02-17-.25 and Rule 0800-02-18-.02

Charges for Medical Reports

Consistent with the statute governing these transactions (T.C.A. § 50-6-204), a provider may use code **Z0710** to 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.

Health care providers and facilities shall be reimbursed up to the usual and customary amount, as defined in these Rules at 0800-02-.03, for copying x-rays, microfilm, or other nonpayer records. State-specific code **Z0710** shall be used when billing for copies.

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 the fees listed in the rate table for chiropractic and physical medicine CPT® codes. An office visit for a chiropractor 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 at the time of service of a 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 85% of the rates listed in the rate tables for E/M and General Medicine codes (based on 200% of Medicare). Utilization review may occur whenever psychological treatment services exceed twelve (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 0800-02-16.

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 the fees listed in the rate tables on the dental tab (60th percentile of FAIR Health's data FH® Charge Benchmarks at the Tennessee state level). If there is no amount listed in the rate tables, 100% of the Medicare amount applies. If no amount is listed in the rate tables and no amount is listed by Medicare, 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 via fax: (615) 253-5265, email: WC.MPC@tn.gov or sent to:

Bureau of Workers' Compensation
Medical Director
Suite 1-B
220 French Landing Drive
Nashville, Tennessee 37243

Each request shall include an unredacted and redacted copy of the following: the form prescribed by the Bureau, a copy of the results of the required reconsideration from the payor, a

summary of attempts to resolve the dispute, a summary of the remaining dispute issues, copies of the original and resubmitted bills in dispute, the explanations of benefits (EOB)/explanation of review (EOR), any supporting documentation, specific information regarding the contacts made with the payor, and all pertinent medical records verified by the provider. If the request for review does not contain proper documentation including the required C-47 form and a redacted copy of all personal information, 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.

The parties will have the opportunity to submit documentary evidence and present arguments to the Committee prior to and during the Committee meeting in which the dispute will be heard. All written submissions to the committee must be received by the Bureau at least one week in advance of the meeting. A redacted copy of all written personal material must be included with any submission. See Rules 0800-02- 17-.21 and 0800-02-17-.22.

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, the fee listed in the rate tables, or a negotiated rate. If no rate is listed in the rate tables, 100% of the applicable Medicare allowable amount would be used in the lesser of comparison.

Durable medical equipment and supplies billed at $100.00 or less for which there is no applicable fee in the rate tables, no Medicare allowable amount, and not included in the facility payment shall be limited to (80%) of billed charges; those that are billed in excess of $100.00 with no amount listed in the rate table and no Medicare allowable amount and are not included in the facility payment are each reimbursed at the manufacturer's invoice amount plus 15% of invoice amount with the 15% capped at $1,000.

"Implantables" or "Surgical Implants" are items that are surgically inserted into the human body for the purpose of replacing, repairing, or improving function or promoting healing that are designed and intended to remain in the human body for a minimum of 30 days or in accordance with Medicare.

For outpatient facility bills, when implants are separately payable by the Medicare status indicator code for Outpatient Prospective Payment System (OPPS) or Ambulatory Payment Classifications (APC), they are only payable to the facility. See Rule 0800-02- 18-.07

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 invoiced amount, 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

Ambulatory Surgery Center (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, such as TENS, 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 14 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. Rules 0800-02-18-.07 and 0800-02-18-.10.

Gap Filled Codes

Gap filled codes are defined as procedural codes not valued by Medicare but for which maximum reimbursement amounts are included in the fee schedule rate tables. **These are applicable April 1, 2026, through March 31, 2027.**

Hearing Aids

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

Home Health Services

Home Health Services are capped at the fees listed in the rate tables (150% 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). Time spent shall include the practitioner's face-to-face time with the patient, time spent reviewing records, reports, studies, and time spent preparing reports.

An IME shall be billed using state-specific code **Z0610** for the first hour for which payment shall not exceed $500. State-specific code **Z0611** shall be used to bill each additional half hour for which the payment shall not exceed $250. **State-specific code Z0310-Impairment Rating (Form Completion) shall not be billed for IME services or in combination with Z0610 or Z0611.** Lab, x-rays, or other tests shall be identified and reimbursed separately according to proper coding.
Prepayment shall not exceed $500. See Rule 0800-02-17-.09

Injection Guidelines

Reimbursement for injection(s) shall include CPT® code **96372 and the appropriate J code(s)**.

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), and the rates for the J codes are listed in the rate tables. Follow the Medicare guidelines on April 1, 2026, 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 (Authorized Treating Physician-ATP) 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 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 be required to provide an impairment rating when the physician believes in good faith that the employee has reached maximum medical improvement. See Rule 0800-02-17-.25.

The authorized treating physician shall receive reimbursement of no more than $250.00, unless a CPP physician. State-specific code **Z0310** shall be used for charges related to the completion of the prescribed form. The payment shall only be made to the authorized treating physician if the authorized treating physician documents consultation with the applicable AMA Guides®.

The analysis should include documentation of the section, page, or table as applicable, as well as the description of the reasoning and methodology based upon the medical records. The fee is payable even if the analysis results in a zero-impairment rating. The physician may bill for an office visit, in addition to **Z0310**, using the appropriate CPT® code for services provided on the same day. Failure to fully complete the form and submit it within the appropriate time frames may, at the discretion of the Administrator, 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 fees for non-hospital settings are listed in the rate tables. (based on 180% of Medicare). If the services are performed in a hospital-owned laboratory, follow CMS rules at the time of service in determining when laboratory charges are paid under Clinical Laboratory Improvement Amendments (CLIA) rules and when they fall under OPPS bundling rules.

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.

Professional fees for pathologists are capped at the fees rates listed in the rate tables (based on 200% of Medicare).

Urine drug screens (UDS) shall be reimbursed using CPT® codes 80305-80307 for presumptive testing and HCPCS codes G0480-G0483 or G0659 for definitive testing. Refer to the rate tables for the maximum allowable rates. UDS using codes 80320-80377 are not reimbursable under the fee schedule. The physician note shall specify which drugs are to be tested and why. 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.

Maximum Allowable Reimbursements

Maximum allowable reimbursements (MAR) are those listed in the rate tables.

Reimbursement to all providers shall be the lesser of the following:

(1) The total of the provider's usual charge; or

(2) The total of the fee or fees listed in the rate tables after applying any applicable modifiers, methodologies, or exceptions set forth in these Rules; or 100% of the Medicare rate at the time of service if no rate is listed in the rate table and the methodology is not set forth in these Rules; or

(3) The MCO/PPO or any other contracted price.

These comparisons shall be determined based on the entire bill or an amount due for a service, rather than on a line-by-line basis. In no event shall reimbursement be in excess of the Bureau's Medical Fee Schedule, unless otherwise authorized by the Administrator. Unless otherwise

indicated, for these Rules, the Medicare rules, procedures and guidelines for the period from April 1, 2026 through March 31, 2027, are those in effect on April 1, 2026.

Missed Appointments

A provider shall receive payment for a missed appointment if the appointment was arranged by the Bureau, the case manager, or employer and the case manager or employer fails to cancel the appointment not less than one (1) business day prior to the time of the appointment. The provider may bill the employer up to $200 for the missed appointment using state-specific code **Z0110** for a new patient visit.

For an established patient, the provider may bill up to $100 using state-specific code **Z0111**. The provider shall not receive payment for diagnostic testing or other services that would have been billed had the patient attended the appointment. 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 -22, or -25** is used, a report explaining the medical necessity must be submitted to the employer. It is not appropriate to use Modifier 22 or 25 for routine billing. 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. 0800-02- 17-.07.

Tennessee state-specific modifiers below may be added to the procedure code when criteria have been met.

1. **Modifier "ON"** - Board certified or board eligible Orthopedists and Neurosurgeons should use the modifier "ON" on the appropriate billing form for reimbursement of 137.5% of the fees listed in the rate tables (275% of Medicare) on surgical codes only. (CPT® 10004-69999). The amount listed in the rate tables is already calculated at 200% of Medicare.

2. **Modifier "NP"** - the following Non-Physician Practitioners properly licensed or certified to perform services shall be reimbursed at 85% of the fees listed in the rate tables

   a) Licensed psychologists and other practitioners providing psychological services.

   b) Physician Assistant (PA) or Advanced Practice Nurse (APN)

      i. "Incident to" rules do not apply.

ii. The maximum reimbursement is 85% of the fees listed in the rate tables which applies to all services except when providing assistance at surgery.

iii. See 0800-02-18-.04(2)(b) for surgical assistant billing.

c) The payor may verify a provider's eligibility by consulting the Tennessee Department of Health's database or by requesting documentation from the provider. See Rule 0800-02-18-.02.

3. Modifier "CP" – Certified Physician Program in Workers' Compensation (CPP) – Physicians certified through the Certified Physician Program shall receive an additional reimbursement for the following services (these fees may be subject to contract negotiations, shall not be billed in the applicable Medicare "global period" and shall only be used for Tennessee jurisdictional claims):

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

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

   c. Assessment of Permanent Impairment and timely completion of the Final Medical Report (C30-A)(billed as and additional code Z0817)... $100.00

Orthotics and Prosthetics

Orthotics and Prosthetics, not supplied under 0800-02-18-.07, should be coded according to the Healthcare Common Procedures Coding System (HCPCS). Maximum reimbursement is the lesser of the billed charge, the fee listed in the rate tables (based on 115% of Medicare), or a negotiated rate. If the orthotic or prosthetic is not included in the rate tables or if the original manufacturer's invoice cost exceeds the amount listed in the rate tables at the time of delivery, the payment for orthotics and prosthetics shall be the higher of the original manufacturer's invoice costs or 115% of the amount listed in the fee schedule. 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 in the HCPCS, 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.

Fitting and customizing may be reimbursed separately using CPT® code **97760**, orthotics management and training initial encounter each 15 minutes; CPT® code **97761**, prosthetics training initial encounter each 15 minutes; and CPT® code **97763**, orthotics/prosthetics management and training, subsequent encounter, each 15 minutes, as appropriate. 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 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**. 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 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 CMS guidelines as of April 1, 2026. 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. For such services, the maximum allowable reimbursement fees are listed in the rate tables (The listed amount is already calculated at 150% of Medicare). 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 April 1, 2026, 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. No adjustments are made for wage-price indices. Services for which no outpatient rates are included in the rate tables may be covered when preauthorized by the payer. The maximum allowable facility reimbursement is the usual & customary amount, which is 80% of the billed charges, as defined in the Bureau's Rules for Medical Payments. Services that qualify for composite APCs or APC 8011, comprehensive observation services, shall be reimbursed at 150% of the OPPS rate listed on the rate tables.

All other outpatient hospital care in all ASCs and all hospitals (including but not limited to observation and emergency room), facility fees shall be reimbursed at a maximum rate of the fee listed in the rate tables (based on 150% of Medicare).

When implants are separately payable by the status indicator code, payment can only be made to the facility.

The maximum allowable fee for the technical components for radiology when done in an ASC or hospital outpatient are capped at the fee listed in the rate tables but may only be separately billed when the Medicare APC code does not include it.

Patients who stay longer than 23 hours post 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 in effect on April 1, 2026 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 is not properly submitted, the employer must notify the provider and specify the reason(s) within 15 business days of receipt of the bill. Any adjustment, delayed, or non-payment of a properly submitted bill shall be communicated to the provider according to Chapter 0800-02-14 and provide appropriate explanation and contact information.

A provider shall request the employer to reconsider a disputed bill (or portion of a bill) within thirty (30) days of receiving notification from the employer that the bill was not properly submitted. The employer shall complete the review of the reconsideration and notify the provider of the determination within thirty (30) days of receiving the request for reconsideration.

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.

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 National Drug Code (NDC) number should be used in determining AWP) plus a $5.10 filing fee. The publications to be used are: (1) Primary reference: Price Alert from Medi-Span, available online at the following website: Medi-Span Price Rx: Online Drug Pricing Tool | Wolters Kluwer (2) Secondary reference: (for drugs NOT found in Price Alert) the Red Book, available online at: Micromedex RED BOOK 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, **at the time of service**.

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.

A generic drug shall be substituted for any brand name drug unless there is no pharmaceutical and bioequivalent drug available, or the prescribing physician indicates that substitutions are prohibited by including "dispense as written" or "no substitution allowed", along with a statement in the prescriber's handwriting that the brand drug is medically necessary.

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 shall 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) and Speech Therapy

Reimbursement for physical, occupational, and speech visits shall not exceed the lesser of billed charges, the fees listed in the rate tables (based on 180% of Medicare as of April 1, 2026), or a negotiated rate, no matter where the services are performed, except home health services.

There shall be no payment allowed for any modalities or therapeutic procedures performed in excess of 4 per day, per type of therapy, per employee. No additional reductions for relative value units (RVUs) should be applied. There shall be no reimbursement for hot packs or cold packs.

When determining the correct number of units for billing or reimbursement for time-based therapy codes, minutes of service specified in the code description shall be rounded to the nearest unit. For example, for codes with 15 minutes of time in the description, a unit shall be billed after 8 minutes of therapy. If the sum of two services is 8 minutes or more, the service provided for the greater amount of time is to be reimbursed as follows:

a) 1 unit is greater than or equal to 8 minutes and less than or equal to 22 minutes.
b) 2 units is greater than or equal to 23 minutes and less than or equal to 37 minutes.
c) 3 units is greater than or equal to 38 minutes and less than or equal to 52 minutes.
d) 4 units is greater than or equal to 53 minutes and less than or equal to 67 minutes.

For Functional Capacity Evaluations (FCE's) the four-unit (time measurement) maximum may not

apply as long as the documentation supports the extra units. Use CPT® code 97750, physical performance test or measurement, with written report, each 15 minutes, to bill for Functional Capacity Evaluations.

For Work Hardening/Conditioning Programs use the CPT® code 97545, work hardening/conditioning; initial 2 hours and CPT® code 97546, work hardening/conditioning. Each additional hour shall be billed for a maximum of 6 hours per day or 60-hour maximum and are subject to utilization review prior approval.

Physical, occupational, or speech 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 not exceed 85 % of the maximum allowable reimbursement for an assistant surgeon (see surgery), billed with modifier **-80**. These services shall be billed using the **-AS** modifier and are subject to the applicable Medicare assistant-at-surgery guidelines.

The need for a surgical assistant, assisting surgeon, co-surgeon, second surgeon or team surgery will follow the assistant at surgery designation in the rate tables.

Physician Assistants and Advance Practice Nurses Reimbursement except those defined as "assistants at surgery"

> Reimbursement for properly licensed or certified Physician Assistants and Advance Practice Nurses for all services except those defined as "assistants at surgery" is capped at 85% of the fees listed in the rate tables for their supervising physician (subject to Medicare rules for billing). "Incident to" billing for PAs or APNs is not billable or payable. Modifier "NP" shall be used. See Rule 0800- 02-18-.02.

Physician Office Visits

General Medicine and Evaluation and Management Codes are capped at a maximum of the fee listed in the rate tables (based on 200% of Medicare). See Rule 0800-02-18-.02.

Preauthorization

Preauthorization means that the employer, prospectively, or concurrently authorizes 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 to authorize or not authorize the service requested by a medical provider shall result in the authorization being deemed approved. See Rules 0800-02-17-.03 and 0800-02-17-.19

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

Effective April 1, 2026, the maximum allowable rate for professional services fees shall be the fees found in the rate tables with the exception of the application of modifiers, methodologies, or exceptions set forth in these Rules (Chapter 0800-02-17, Chapter 0800-02-18, or Chapter 0800-02-19).

Professional Fee Service Category	Tennessee Specific Conversion Percentage
Surgery (Orthopedics and Neurosurgery with Modifier ON for surgical codes: CPT® 10004-69999)	275%
Surgery	200%
Radiology	200%
Pathology	200%
Physical/Occupational Therapy	180%
Chiropractic	180%
General Medicine, (including Evaluation & Management- E&M) without modifier	200%
Home Health Services	150%
Emergency Care (CPT® 99281-99292)	200%
Dentistry	60th percentile of FAIR Health's FH® Charge Benchmarks at the Tennessee state level

Professional Fee Service Category	Tennessee Specific Conversion Percentage
Anesthesiology	75.00 per unit

Example Fee Calculations of the same CPT Code:

(Fee in rate Table) x (adjustment for applicable modifier) = Maximum allowable rate

CPT® **99204** (E/M)
Maximum Allowable Rate = $332.28

CPT® **99204** (E/M)
For CPP physicians (refer to Certified Physician Program (CPP) Registry ,
Maximum Allowable Rate = $332.28 + (Z0815) $80.00 = $412.28 total

CPT® **99204-NP** (E/M)
For **NP** modifier (Physician Assistant or Advance Practice Nurse)
$332.28 x 0.85 = $282.44

CPT® **25444**
Maximum Allowable Rate = $1395.07

CPT® **25444-ON**
For "ON" modifier (Board certified or board eligible Orthopedists and Neurosurgeons)
$1395.07x 1.375 = $1918.22

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 state-specific code **Z0510** 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, Ill, 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 the fees listed in the rate tables (based on 200% of Medicare) for both the technical and professional fees. This includes Diagnostic Facilities and Urgent Care Facilities. See Rule 0800-02-18-.02.

Rate Table or Rate Tables

Rate tables are defined as the established fees for services provided by the Bureau and updated in accordance with these Rules. **The current version is applicable April 1, 2026, through March 31, 2027.**

Fees Listed in the Rate Tables:

The rate tables have already been calculated based on the listed percentage of Medicare below. With the exception of the surgical modifiers, Certified Physician Program, assistant-to-surgery, and the adjustment for mid-level providers, the listed fee is the correct maximum allowable amount.

- Evaluation and Management: 200%
- Emergency Care (CPT® 99281-99292) 200%
- Anesthesia $75/unit; (Base units listed in the rate tables) the total anesthesia fee is the sum of the base units and the time value which has been converted into units plus any physical status modifiers allowed by Medicare
- Surgery: 200%
- Radiology: 200%
- Laboratory: 180%
- Pathology: 200%
- General Medicine: 200%
- Physical Medicine 180%
- Dental: the listed amount (60% of FAIR Health national data)
- Home Health: 150%
- Ambulance: 150%
- HCPCS: the listed amount
- State Specific **Z codes**: the listed amount
- "**ON**" modifier for Board-certified or Board-eligible orthopedics and neurosurgery: 275% of Medicare or 137.5% of the surgery rates listed in the Rate Table for Surgery codes.
- "**NP**" modifier for properly licensed or certified Advanced Practice Nurses, Physician Assistants, and Psychologists: 85% of the listed rates in the Rate Tables for E/M and General Medicine.
- Certified Physicians Program: the amount listed in the Rate Table for **Z**

codes, Z0815, Z0816, Z0817.

Surgery, Surgical Assistants and Modifiers

Physicians performing surgery receive a maximum allowable of the fees listed in the rate tables for surgical codes (based on 200% of Medicare). Orthopedic Surgeons and Neurosurgeons may receive **137.5%** of the fees listed in the rate tables (based on 275% of Medicare) on surgical codes only. (CPT® 10004-69999).

Multiple Procedures: Maximum reimbursement shall be based on 100% of the fee listed in the rate tables 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 in effect on April 1, 2026.

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 fee in the rate table when adding Modifier **-80, -81,** or **-82** to the surgical procedure code. Procedures billed with assistant-to-surgery modifiers are subject to Medicare guidelines for this service. Please refer to the rate tables for CPT® code eligibility. 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 with the exception of any geographic restriction. The maximum allowable fees are listed in the rate tables. CPT® codes eligible for telehealth are designated in the rate tables. Medical providers shall be paid at the same rate whether services are performed in person or via telehealth. 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.

Tennessee State-Specific "Z" codes

Chapter 17 (0800-02-17-.09)

Code	Notes	Description	Amount
Z0610	State specific code Z0610 shall be used to bill the first 1st hour (shall not to exceed $500).	IME/Initial hour	shall not exceed **$500**
Z0611	State specific code Z0611 shall be used to be each additional half hour (shall not to exceed $250 per half hour)	IME/Additional half hour	shall not exceed **$250**
Z0310	State specific code Z0310 - Impairment Rating (Form Completion) shall not be billed for IME services or in combination with codes Z0610 and Z0611, see 0800-02-17-.25	Final Medical Report Form C-30A	up to **$250**

Chapter 17 (0800-02-17-.14)

Code	Notes	Description	Amount
Z0110	The provider may bill the employer up to $200 for missed appointment using state specific code Z0110 for new patient visit	Missed Appointment/Initial visit	up to **$200**
Z0111	For an established patient, the provider may bill up to $100 using state specific code Z0111	Missed Appointment/Follo w-up visit	**up to $100**

Chapter 17 0800-02-17-.15

Code	Notes	Description	Amount
Z0710	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 Z0710: initial and subsequent reports - not to exceed $10 for reports twenty (20) pages or less in length, and twenty-five (25) cents per page after the first twenty pages.	Medical Reports/Copies	not to exceed **$10** (first 20 pages) , **25 Cents** per page after the first 20 pages

Z0210	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 charged by the physician and paid by the requesting party using specific code Z0210 ($200 for an hour or less)	Causation/Subsequent request, initial hour	$200
Z0211	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 charged by the physician and paid by the requesting party using specific code Z0210 ($200 for an hour or less) and state-specific code Z0211 ($100 for each additional hour).	Causation/Subsequent request, each additional hour	$100
Z0410	Extra time spent in explanation or discussion with an injured worker or the case worker (that is separate from the discussion with injured worker) may be charged on the same day as office visit charge provided the extra time is equal to or greater than fifteen (15) minutes. State specific code Z0410 shall be used for thirty (30) minutes or less ($40 for 15-30 minutes).	Case Management/ Discussion 30 minutes or less	$40
Z0411	State specific code Z0411 shall be used for greater than thirty (30) minutes. ($80 for 31 minutes or greater)	Case Management/ Discussion over 30 minutes	$80
Z0510	Extra time spent assessing, counseling, or providing behavioral intervention to a Workers' Compensation patient for substance and/or alcohol use, or for substance and/or alcohol use disorder may be charged on the same day as an office Extra time spent assessing, counseling, or providing behavioral intervention to a Workers' Compensation patient for substance and/or alcohol use, or for substance and/or alcohol use disorder may be charged on the same day as an office visit charge using state-specific code Z0510 up to a maximum of eighty dollars ($80) in addition to a standard E/M code.	Behavioral Health	up to **$80**

Chapter 17 (0800-02-17-.25)

Code	Notes	Description	Amount
Z0310	State specific code Z0310 - Impairment Rating (Form Completion) shall not be billed for IME services or in combination with codes Z0610 and Z0611	Final Medical Report (Form C-30A)	up to **$250**

Chapter 18 (0800-02-18-.02)

Code	Notes	Description	Amount
Z0815	Certified Physician Program in Workers' Compensation (CPP) - Physicians certified through the Certified Physician Program (CPP) shall receive an additional reimbursement for the following services: **(a) Initial Assessment** (billed as an additional code Z0815) $80	Certified Physician Program/initial visit	$80
Z0816	Certified Physician Program in Workers' Compensation (CPP) - Physicians certified through the Certified Physician Program shall receive an additional reimbursement for the following services: **(b) Subsequent visit** (billed as an additional code Z0816) $40	Certified Physician Program/Follow-up visit	$40
Z0817	Certified Physician Program in Workers' Compensation (CPP) - Physicians certified through the Certified Physician Program shall receive an additional reimbursement for the following services: **(c) Assessment of Permanent Impairment and timely completion of the Final Medical Report (C30-A)** (billed as an additional code Z0817) $100.	Certified Physician Program/Permanent impairment rating	$100

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, Ill 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. Orders by the medical director overturning a utilization review denial do not necessarily guarantee payment. Authorization for payment by the adjuster is still necessary. See Rule 0800-02-17-.03 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 these items must be listed with the applicable HCPCS codes.

Durable Medical Equipment

Durable medical equipment (“DME”) including home DME, infusion and oxygen services, other than implantables, shall be reimbursed at the lesser of the billed charges, the fees listed in the rate tables, or a negotiated rate. If no rate is listed in the rate tables, 100% of the applicable Medicare allowable amount would be used in the lesser of comparison.

Durable medical equipment and supplies billed at $100.00 or less for which there is no applicable fee in the rate tables, no Medicare allowable amount, and not included in the facility payment shall be limited to (80%) of billed charges; those that are billed in excess of $100.00 with no amount listed in the rate table and 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.

Orthotics and Prosthetics

Maximum reimbursement is the lesser of the billed charge, the amount listed in the rate tables, or a negotiated rate. If the orthotic or prosthetic is not included in the rate tables or if the original manufacturer’s invoice cost exceeds the amount listed in the rate tables at the time of delivery, the payment for orthotics and prosthetics shall be the higher of the original manufacturer’s invoice costs or 115% of the amount listed in the rate tables. 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 at the lesser of the billed charges, the fee listed in the rate tables, or a negotiated rate. If no rate is listed in the rate tables, 100% of the applicable Medicare allowable amount would be used in the lesser of comparison. Supplies billed at $100.00 or less for which there is no applicable fee in the rate tables, no Medicare allowable amount, and not included in the facility payment shall be limited to (80%) of billed charges; those that are billed in excess of $100.00 with no amount listed in the rate table and 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.

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:

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

Skilled Nursing Facilities

Skilled Nursing Facilities that are licensed/accredited shall be paid according to the CMS National unadjusted rates for urban or rural facilities in effect on the date of service, including applicable carveouts, and adjustments made under "Patient-Drive Payment Model" (PDPM) or later CMS methodology. The bill shall include the applicable "Resource Utilization Group" (RUG) for each day. Hospital per-diem and stop loss calculations do not apply to these facilities. 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** - $2,347.00 for the first 7 days; $2,032.00 per day for each day thereafter. This includes Intensive Care (ICU) & Critical Care (CCU) if not a trauma admission.

- **Medical Admissions** - $1,932.00 for the first 7 days; $1,670.00 per day for each day thereafter.

- **Rehabilitation Hospitals** - $1,145.00 for the first 7 days; $935.00 per day for each day thereafter.

- **Psychiatric Hospitals** (applicable to chemical dependency as well) maximum allowable amount is $830.00 per day.

- **Trauma Level 1** - All trauma care at any licensed Level 1 Trauma Center only shall be reimbursed at a maximum rate of $4,725.00 per day.

See Rule 0800-02-19-.03.

Non-covered charges

Non-covered items are convenience items and 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 should be 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

Billed charges (after subtracting $15k of implants)...............**$25,000.00**

Maximum Rate per Day
$2,347 for the first seven days, for three days

Maximum allowable payment for normal DRG stay $7,041.00

Amounts due hospital for implants $2,500.00

Maximum fee schedule amount $7,041.00 + $2,500.00 = **$9,541.00**

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 method of payment reimbursement factor established for an inpatient hospital stay.

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 **$21,788.00** for Non-Trauma Admissions and **$31,500.00** for Trauma Admissions. Amounts for items set forth in Rule 0800-02-19-03 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:

Total Billed Charges	$120,000.00
Billed charges (after subtracting the amount for implants)	**$100,000.00**

Maximum rate per day: $2347.00 first seven (7) days then $2,032.00 per day each day thereafter (Number billed days: 9)

Maximum allowable payment for normal MSDRG stay	$20,493.00
Total difference, charges over and above maximum payments	$79,507.00

(If this amount is $21,788.00 or less for non-trauma, then stop loss is not applicable.)

Difference over and above $21,788.00 stop-loss	$57,719.00
Payable under stop-loss (80% of $57,719.00)	$46,175.20
Amounts due hospital for implants	$5,000.00
Maximum fee schedule amount: 20,493.00 + 46,175.20 + 5,000 =	**$71,668.20**

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 International Classification of Diseases, Ninth Revision (ICD-9) diagnosis code of 800 to 959.99, or International Classification of Diseases, Tenth Revision (ICD-10) code that is (or includes) SOO.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: Trauma Centers.

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