TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 134: BENEFITS – GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER C. MEDICAL FEE GUIDELINES
AMEND 28 TAC §134.204 and NEW 28 TAC §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250

1. INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (division) adopts non substantive amendments to 28 Texas Administrative Code (TAC) §134.204 and adopts new 28 TAC §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 concerning medical fee guidelines for workers' compensation. The amended and new sections are adopted without changes to the proposed text published in the March 18, 2016, issue of the *Texas Register* (41 TexReg 2118). A correction of error notice was published in the April 1, 2016, issue of the *Texas Register* (41 TexReg 2523) to correct errors in the preamble published in the March 18, 2016, issue of the *Texas Register* (41 TexReg 2118). No request for a public hearing was submitted to the division.

New 28 TAC §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 include non-substantive changes to conform to current agency style, correct grammatical errors, and renumber or reletter subsections. The new sections become applicable for workers' compensation specific codes, services and programs provided on or after September 1, 2016 to allow system participants

sufficient time to adjust to the reorganization. The adoption of the repeal of §134.202 and §134.302 is published elsewhere in this issue of the *Texas Register*.

In accordance with Government Code §2001.033, the division's reasoned justification for these rules is set out in this order, which includes the preamble. The following paragraphs include a detailed section-by-section description and reasoned justification of amendments to 28 TAC §134.204 and new 28 TAC §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250.

2. REASONED JUSTIFICATION. The amendments and new sections are necessary to reorganize existing 28 TAC §134.204 by adding its requirements to new 28 TAC §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 for workers' compensation specific codes, services, and programs provided on or after September 1, 2016. The division clarifies that the reorganization is non-substantive and does not include new requirements for system participants. The new sections largely mirror existing 28 TAC §134.204 and include non-substantive changes. The reorganization creates a more comprehensive format by separating the billing and reimbursement requirements for multiple services into new sections. The reorganization is necessary to streamline compliance for system participants and streamline future amendments to the guidelines. The reorganization will improve the division's ability to make future amendments to the multiple services without resulting in one complex rule project. The division declines to repeal existing 28 TAC §134.204 at this time. The division clarifies that existing 28 TAC §134.204 will remain applicable for

workers' compensation specific codes, services, and programs provided from March 1, 2008 until September 1, 2016.

Amended 28 TAC §134.204. Amended 28 TAC §134.204 addresses the medical fee guideline for workers' compensation specific codes, services, and programs provided from March 1, 2008 until September 1, 2016. Amended 28 TAC §134.204(a)(2) deletes the phrase "on or after" and adds the word "from" and the phrase "until September 1, 2016." These amendments are necessary to prevent the applicability of existing 28 TAC §134.204 from running concurrently with new 28 TAC §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250. The new sections replace existing 28 TAC §134.204 for workers' compensation specific codes, services, and programs provided on or after September 1, 2016. The division clarifies that existing 28 TAC §134.204 and the new sections will not be applicable for workers' compensation specific codes, services, and programs at the same time. The delayed applicability date of September 1, 2016 will allow system participants sufficient time to adjust to the reorganization before the new sections become applicable for workers' compensation specific codes, services, and programs.

New 28 TAC §134.209. New 28 TAC §134.209 addresses the applicability for the medical fee guideline for workers' compensation specific codes, services, and programs outlined in new §§134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250. New 28 TAC §134.209 largely mirrors existing 28 TAC §134.204(a), with non-substantive changes. New 28 TAC §134.209 does not include the title "Medical Fee Guideline for Workers' Compensation Specific Services" and

instead includes the title “Applicability.” The title “Applicability” better reflects the content of the new 28 TAC §134.209. The new section also does not include the phrase “applicability of this rule is as follows:” because the new section title is “Applicability” therefore including the phrase is redundant.

New 28 TAC §134.209(a)(1) – (5) largely mirrors existing 28 TAC §134.204(a)(1)(A) – (E), with non-substantive changes. New 28 TAC §134.209(a) does not include the phrase “This section applies” and instead includes the phrase “Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title apply” to specify the new citation numbers applicable to workers’ compensation specific codes, services, and programs.

New 28 TAC §134.209(a) does not include subparagraphs (A) – (E) and instead includes paragraphs (1) – (5). The renumbering is necessary because the phrase “applicability of this rule is as follows:” is excluded.

New 28 TAC §134.209(a)(1) does not include the title of the referenced rule citation in existing 28 TAC §134.204(a)(1)(A) “(relating to Medical Fee Guideline for Professional Service)” to conform to current agency style.

New 28 TAC §134.209(b) largely mirrors existing 28 TAC §134.204(a)(2), with non-substantive changes. New 28 TAC §134.209(b) does not include the phrase “this section applies” and instead includes the phrase “Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title apply” to specify the new citation numbers applicable to workers’ compensation specific codes, services, and programs.

New 28 TAC §134.209(b) does not include the date “March 1, 2008” and instead includes the date “September 1, 2016.” This is necessary because the new sections will have a delayed applicability date. The delayed applicability date allows time for system participants to adjust to the reorganization and new sections before the new sections become applicable for workers’ compensation specific services. The division expects the new sections to become applicable to workers’ compensation specific codes, services, and programs provided on or after September 1, 2016.

New 28 TAC §134.209(c) includes a severability clause. The inclusion is necessary to ensure that any invalidity of the rules will not affect parts of the rules given effect without the invalid provision or application.

New 28 TAC §134.209(d) largely mirrors existing 28 TAC §134.204(m), with non-substantive changes. New 28 TAC §134.209(d) does not include the introductory sentence “the following shall apply to Treating Doctor Examination to Define the Compensable Injury” to conform to current agency style.

New 28 TAC §134.209(d) does not include the phrase “this type of” because the phrase is no longer necessary without the introductory sentence “the following shall apply to Treating Doctor Examination to Define the Compensable Injury.”

New 28 TAC §134.209(d) does not include the title of the referenced rule citation in existing 28 TAC §134.204(m) “(relating to Treating Doctor Examination to Define Compensable Injury)” to conform to current agency style.

New 28 TAC §134.209(d) includes the phrase “a treating doctor” and the phrase “to define the compensable injury” because the phrases are necessary to specify the type of examination.

New 28 TAC §134.210. New 28 TAC §134.210 addresses general provisions applicable to the medical fee guideline for workers’ compensation specific services. New 28 TAC §134.210 largely mirrors existing 28 TAC §134.204(a)(5), (b) – (d), and (n), with non-substantive changes. New 28 TAC §134.210 includes the title “Medical Fee Guideline for Workers’ Compensation Specific Services” because the title reflects the content of the section.

New 28 TAC §134.210 does not include existing 28 TAC §134.204(a)(3) and (4) because the paragraphs contain rule citations that are no longer effective.

New 28 TAC §134.210(a) largely mirrors existing 28 TAC §134.204(a)(5), with non-substantive changes. New 28 TAC §134.210(a) does not include the phrase “the Texas Department of Insurance, Division of Workers’ Compensation (Division),” and instead includes the word “division” to conform to current agency style.

New 28 TAC §134.210(a) does not include the title of the referenced rule citation in existing 28 TAC §134.204(a)(5) “(relating to MDR of Medical Necessity Disputes by Independent Review Organizations)” to conform to current agency style.

New 28 TAC §134.210(b)(1) – (3) largely mirrors existing 28 TAC §134.204(b)(1) – (3), with non-substantive changes. New 28 TAC §134.210(b) does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.210(b)(1) does not include the introductory word “Billing” to conform to current agency style.

New 28 TAC §134.210(b)(1) includes the phrase “Current Procedural Terminology” before the abbreviation “CPT”. The non-substantive change is necessary for clarity.

New 28 TAC §134.210(b)(1) does not include the word “codes” because the word is used twice to describe Level I and Level II Healthcare Common Procedure Coding System codes and the second use is repetitive.

New 28 TAC §134.210(b)(1) does not include the abbreviation “HCPs” and instead includes the phrase “health care providers.” The non-substantive change is necessary for clarity.

New 28 TAC §134.210(b)(1) does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.210(b)(2) does not include the introductory word “Modifiers” to conform to current agency style.

New 28 TAC §134.210(b)(2) includes the word “insurance” before the word “carriers” to conform to current agency style.

New 28 TAC §134.210(b)(2) does not include subsection “(n)” and instead includes subsection “(e)” because new 28 TAC §134.210(e) contains division-specific modifiers.

New 28 TAC §134.210(b)(3) does not include the introductory phrase “Incentive Payments” to conform to current agency style.

New 28 TAC §134.210(b)(3) does not include the phrase “subsections (d), (e), (g), (i), (j), and (k)” and instead includes the phrase "§§134.220, 134.225, 134.235, 134.240, and 134.250 of this title and subsection (d)" because the new sections reflect the content of existing 28 TAC §134.204(e), (g), (i), (j), and (k).

New 28 TAC §134.210(b)(3) does not include the title of the referenced rule citation in existing 28 TAC §134.204(b)(3) “(relating to Incentive Payments for Workers’ Compensation Underserved Areas)” to conform to current agency style.

New 28 TAC §134.210(c) mirrors existing §134.204(c).

New 28 TAC §134.210(d)(1) – (3) largely mirrors existing 28 TAC §134.204(d)(1) – (3), with non-substantive changes. New 28 TAC §134.210(d) does not include the phrase “of the Labor Code” after the citation and instead includes the phrase “Labor Code” before the citation to conform to current agency style.

New 28 TAC §134.210(d)(2) does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.210(d)(3) does not include the title of the referenced rule citation “(relating to Medical Reimbursement)” to conform to current agency style.

New 28 TAC §134.210(e)(1) – (24) largely mirrors existing 28 TAC §134.204(n)(1) – (24), with non-substantive changes. New 28 TAC §134.210(e) does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.210(e), (e)(1), and (18) do not include the abbreviation “HCP” and instead include the phrase “health care provider.” The non-substantive change is necessary for clarity.

New 28 TAC §134.210(e)(14) and (15) do not include the word “of” in the phrase “of at least” to conform to current agency style.

New 28 TAC §134.210(e)(20) does not include the phrase “maximum medical improvement” and instead includes the abbreviation “MMI.” The non-substantive change is necessary for consistency.

New 28 TAC §134.215. New 28 TAC §134.215 addresses the medical fee guideline for home health services. New 28 TAC §134.215 largely mirrors existing 28 TAC §134.204(f), with non-substantive changes. New 28 TAC §134.215 includes the title “Home Health Services” because the title reflects the content of the section.

New 28 TAC §134.215 does not include subsection “(f)” because new 28 TAC §134.215 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.215 does not include unnecessary punctuation because of the change to sentence structure.

New 28 TAC §134.215 includes the phrase “the maximum allowable reimbursement (MAR)” for clarity. New 28 TAC §134.215 does not include the phrase “to determine the MAR” because the MAR provided for home health services is 125% of the Texas Medicaid fee schedule. New 28 TAC §134.215 also does not include the phrase “the MAR” because the phrase “maximum allowable reimbursement (MAR)” is included and the phrase “the MAR” is repetitive.

New 28 TAC §134.220. New 28 TAC §134.220 addresses the medical fee guideline for case management services. New 28 TAC §134.220 largely mirrors existing

28 TAC §134.204(e), with non-substantive changes. New 28 TAC §134.220 includes the title “Case Management Services” because the title reflects the content of this section.

New 28 TAC §134.220 does not include a subsection “(e)” because new 28 TAC §134.220 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.220 does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.220 does not include the word “is” and instead includes the word “are”. The non-substantive change is necessary to correct a grammatical error.

New 28 TAC §134.220 does not include the abbreviation “HCP” and instead includes the phrase “health care provider.” The non-substantive change is necessary for clarity.

New 28 TAC §134.225. New 28 TAC §134.225 addresses the medical fee guideline for functional capacity evaluations. New 28 TAC §134.225 largely mirrors existing 28 TAC §134.204(g), with non-substantive changes. New 28 TAC §134.225 includes the title “Functional Capacity Evaluations” because the title reflects the contents of this section.

New 28 TAC §134.225 does not include a subsection “(g)” because new 28 TAC §134.225 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.225 does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.230. New 28 TAC §134.230 addresses the medical fee guideline for return to work rehabilitation programs. New 28 TAC §134.230 largely mirrors existing 28 TAC §134.204(h), with non-substantive changes. New 28 TAC §134.230 includes the title “Return to Work Rehabilitation Programs” because the title reflects the content of this section.

New 28 TAC §134.230 does not include a subsection “(h)” because new 28 TAC §134.230 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.230 does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.230 includes the word “insurance” before the word “carrier” to conform to current agency style.

New 28 TAC §134.230(1)(A) includes the phrase “maximum allowable reimbursement (MAR).” The non-substantive change is necessary for clarity.

New 28 TAC §134.230(3)(B) does not include the numeral “8” and instead includes the word “eight” for consistency and to conform to current agency style.

New 28 TAC §134.235. New 28 TAC §134.235 addresses the medical fee guideline for return to work/evaluation of medical care examinations. New 28 TAC §134.235 largely mirrors existing 28 TAC §134.204(k), with non-substantive changes.

New 28 TAC §134.235 includes the title “Return to Work/Evaluation of Medical Care Examinations” because the title reflects the content of this section.

New 28 TAC §134.235 does not include a subsection “(k)” because new 28 TAC §134.235 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.235 does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.235 includes the phrase “maximum medical improvement/impairment rating (MMI/IR).” The non-substantive change is necessary for clarity.

New 28 TAC §134.235 does not include the phrase “subsection (i) of this section” and instead includes the phrase “§134.240 of this title.” The non-substantive change is necessary because new 28 TAC §134.240 reflects the content of existing 28 TAC §134.204(i).

New 28 TAC §134.239. New 28 TAC §134.239 addresses billing for work status reports conducted separately from designated doctor examinations, maximum medical improvement evaluations, or impairment rating examinations. New 28 TAC §134.239 largely mirrors existing 28 TAC §134.204(l), with non-substantive changes. New 28 TAC §134.239 includes the title “Billing for Work Status Reports” because the title reflects the content of this section.

New 28 TAC §134.239 does not include a subsection “(l)” because new 28 TAC §134.239 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.239 does not include the sentence “the following shall apply to work status reports” because the sentence is no longer necessary to separate subsections.

New 28 TAC §134.239 does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.239 does not include the phrase “subsections (i) and (j) of this section” and instead includes the phrase “§134.240 and §134.250 of this title” because new 28 TAC §134.240 and §134.250 reflects the content of existing 28 TAC §134.204(i) and (j).

New 28 TAC §134.239 does not include the title of the referenced rule citation in existing 28 TAC §134.204(l) “(relating to Work Status Reports)” to conform to current agency style.

New 28 TAC §134.240. New 28 TAC §134.240 addresses the medical fee guideline for designated doctor examinations. New 28 TAC §134.240 largely mirrors existing 28 TAC 134.204(i), with non-substantive changes. New 28 TAC §134.240 includes the title “Designated Doctor Examinations” because the title reflects the content of this section.

New 28 TAC §134.240 does not include a subsection “(i)” because new 28 TAC §134.240 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.240 does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.240(1)(A) – (B) does not include the phrase “subsection (j) of this section” and instead includes the phrase “§134.250 of this title” because new 28 TAC §134.250 reflects the content of existing 28 TAC §134.204(j).

New 28 TAC §134.240(1)(C) – (F) and (2)(A) – (C) do not include the phrase “subsection (k) of this section” and instead includes the phrase “§134.235 of this title” because new 28 TAC §134.235 reflects the content of existing 28 TAC §134.204(k).

New 28 TAC §134.240(2) does not include the word “subsection” and instead includes the word “section” because new 28 TAC §134.240 is an independent section.

New 28 TAC §134.250. New 28 TAC §134.250 addresses the medical fee guideline for maximum medical improvement evaluations, and impairment rating examinations. New 28 TAC §134.250 largely mirrors existing 28 TAC 134.204(j), with non-substantive changes. New 28 TAC §134.250 includes the title “Maximum Medical Improvement/Impairment Rating Examinations” because the title reflects the content of this section.

New 28 TAC §134.250 does not include a subsection “(j)” because new 28 TAC §134.250 is an independent section that contains an implied subsection and the lettering is no longer necessary to conform to Texas Register requirements.

New 28 TAC §134.250 does not include unnecessary capitalization to conform to current agency style.

New 28 TAC §134.250(1) includes the phrase “maximum allowable reimbursement (MAR).” The non-substantive change is necessary for clarity.

New 28 TAC §134.250(1)(D) does not include unnecessary punctuation to conform to current agency style.

New 28 TAC §134.250(1)(E) does not include the phrase “Act and Division rules in” and instead includes the phrase “Labor Code and” to conform to current agency style.

New 28 TAC §134.250(1)(E) does not include the title of the referenced rule citation in existing 28 TAC §134.204(j)(1)(E) “(relating to Impairment and Supplemental Income Benefits)” to conform to current agency style.

New 28 TAC §134.250(2) does not include the phrase “An HCP” and instead includes the phrase “A health care provider.” The non-substantive change is necessary for clarity.

New 28 TAC §134.250(2) does not include the phrase “Act and Division rules in” and instead includes the phrase “Labor Code and” to conform to current agency style.

New 28 TAC §134.250(2)(A) - (C) and (3)(B)(i) - (ii) does not include the word “subsection” and instead includes the word “section” because new 28 TAC §134.250 is an independent section.

New 28 TAC §134.250(3)(A)(ii) corrects punctuation to conform to current agency style.

New 28 TAC §134.250(3)(B) and (3)(B)(i) do not include unnecessary punctuation to conform to current agency style.

New 28 TAC §134.250(4)(A) does not include the abbreviation “HCP” and instead includes the phrase “health care provider.” The non-substantive change is necessary for clarity.

New 28 TAC §134.250(4)(B) does not include the citation §130.6 because the citation 28 TAC §130.6 is obsolete.

New 28 TAC §134.250(4)(B) does not include the title of the referenced rule citation in existing 28 TAC §134.204(j)(4)(B) “(relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings)” to conform to current agency style.

New 28 TAC §134.250(4)(C)(ii)(I) does not include the numeral “4th” and instead includes the word “fourth” to conform to current agency style.

New 28 TAC §134.250(4)(C)(iv) does not include the title of the referenced rule citation in existing 28 TAC §134.204(j)(4)(C)(iv) “(relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment)” to conform to current agency style.

New 28 TAC §134.250(4)(C)(v) does not include the abbreviation “HCP” and instead includes the phrase “health care provider.” The non-substantive change is necessary for clarity.

New 28 TAC §134.250(5) does not include the word “subsection” and instead includes the word “section” because new 28 TAC §134.250 is an independent section.

New 28 TAC §134.250(6) does not include the phrase “Act and Division Rules” and instead includes the phrase “Labor Code and” to conform to current agency style.

3. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General

Comment: A commenter requests the division consider increasing reimbursements for participating designated doctors as necessary to safekeep the current process. The commenter also requests the division consider a fee of $100.00 for no-show appointments when an injured employee fails to show for a designated doctor exam. The commenter states that there are a lot of hours and sacrifice involved to do a competent and complete job.

Agency Response: The division declines to make the suggested change. The commenter’s request is considered substantive and outside the scope of the non-substantive reorganization of 28 TAC §134.204.

Comment: A commenter states that part of 28 TAC §127.10(a)(3) (regarding General Procedures for Designated Doctor Examinations) does not read as intended and requests the division to delete the phrase “within one working day of the examination” and add the phrase “at least one working day prior to the examination.”

Agency Response: The division declines to make the suggested change. The commenter’s request relates to 28 TAC Chapter 127 and is outside the scope of the non-substantive reorganization of 28 TAC §134.204.

28 TAC §134.204 and 28 TAC §134.210

Comment: A commenter requests a CPT code in the division-specific modifiers section of 28 TAC §134.204(n)(5) and 28 TAC §134.210(e)(5) be changed.

Agency Response: The division appreciates the comment but declines to make the suggested change at this time because the request is considered a substantive change and outside the scope of the non-substantive reorganization 28 TAC §134.204.

28 TAC §134.250

Comment: A commenter questions why a $50.00 reimbursement for incorporating a specialist's report in the final assignment of an impairment rating is allowed only for non-musculoskeletal body areas. The commenter requests that a designated doctor be reimbursed when incorporating the findings of all types of additional testing into the maximum medical improvement and/or impairment rating report, and requests the division remove "non-musculoskeletal" from the rule.

Agency Response: The division declines to make the suggested change. The commenter's request is considered substantive and outside the scope of the non-substantive reorganization 28 TAC §134.204.

4. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL

For: None

For with changes: None

Against: None

Neither for nor against: Two individuals

5. STATUTORY AUTHORITY. The amendments and new sections are adopted under Labor Code §§402.00111, 402.061, 408.021, 408.0252, 413.002, 413.007, 413.011, 413.012, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031, and 413.0511.

Labor Code §402.00111 requires the commissioner of workers' compensation to exercise all executive authority, including rulemaking authority, under Title 5 of the Labor Code. Labor Code §402.061 requires the commissioner of workers' compensation to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act. Labor Code §408.021 provides that an injured employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Labor Code §408.0252 permits the commissioner to identify areas of this state in which access to health care providers is less available and may adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. Labor Code §413.002 requires the division to monitor health care providers, insurance carriers, independent review organizations, and workers' compensation claimants who receive medical services to ensure the compliance of those persons with rules adopted by the commissioner relating to health care, including medical policies and fee guidelines. Labor Code §413.007 requires the division to maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used in adopting and administering the medical policies and fee guidelines. Labor Code §413.011 requires the commissioner to adopt health care reimbursement policies and guidelines that

reflect the standardized reimbursement structures found in other health care delivery systems and the fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. Labor Code §413.012 requires the division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable or necessary at the time the review and revision is conducted. Labor Code §413.013 requires the commissioner to establish programs related to health care treatments and services for dispute resolution monitoring and review to ensure compliance with medical policies or guidelines. Labor Code §413.014 requires the commissioner to specify which health care treatments and services require preauthorization or concurrent review by insurance carriers. Labor Code §413.015 requires the commissioner to review and audit insurance carriers payments of charges for medical services to ensure compliance of medical policies and fee guidelines adopted by the commissioner. Labor Code §413.016 requires the division to order a refund of charges paid to a health care provider in excess of those allowed by the medical policies or fee guidelines and investigate the potential violation. Labor Code §413.017 provides for a presumption of reasonableness for medical services consistent with the medical policies and fee guidelines. Labor Code §413.019 provides for payment of interest on delayed payments, refunds, or overpayments. Labor Code

§413.031 provides for medical dispute resolution for a medical service provided. Labor Code §413.0511 requires the medical advisor to make recommendations regarding the adoption of rules and policies to develop, maintain, and review guidelines as provided by Labor Code §413.011.

6. TEXT.

§134.204 Medical Fee Guideline for Workers' Compensation Specific Services

(a) Applicability of this rule is as follows:

(1) This section applies to workers' compensation specific codes, services and programs provided in the Texas workers' compensation system, other than:

(A) professional medical services described in §134.203 of this title (relating to Medical Fee Guideline for Professional Services);

(B) prescription drugs or medicine;

(C) dental services;

(D) the facility services of a hospital or other health care facility; and

(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

(2) This section applies to workers' compensation specific codes, services and programs provided from March 1, 2008 until September 1, 2016.

(3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

(4) For workers' compensation specific codes, services and programs provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.

(5) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(b) Payment Policies Relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:

(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, Division-specific modifiers are identified in subsection (n) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

(3) Incentive Payments. A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (d), (e), (g), (i), (j), and (k) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(d) When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title (relating to Medical Reimbursement).

(e) Case Management Responsibilities by the Treating Doctor is as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

(A) Team members shall not be employees of the treating doctor.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

(B) developing or revising a treatment plan, including any treatment plans required by Division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity.

(B) CPT Code 99362.

(i) Reimbursement to the treating doctor shall be $198. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $50 when a HCP contributes to the case management activity.

(C) CPT Code 99371.

(i) Reimbursement to the treating doctor shall be $18. Modifier "W1" shall be added.

(ii) Reimbursement to a referral HCP contributing to this case management activity shall be $5.

(D) CPT Code 99372.

(i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management activity shall be $12.

(E) CPT Code 99373.

(i) Reimbursement to the treating doctor shall be $90. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management action shall be $23.

(f) To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

(g) The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:

(A) appearance (observational and palpation);

(B) flexibility of the extremity joint or spinal region (usually observational);

(C) posture and deformities;

(D) vascular integrity;

(E) neurological tests to detect sensory deficit;

(F) myotomal strength to detect gross motor deficit; and

(G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:

(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and

(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:

(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);

(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;

(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

(D) static positional tolerance (observational determination of tolerance for sitting or standing).

(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

(1) Accreditation by the CARF is recommended, but not required.

(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.

(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(i) The following shall apply to Designated Doctor Examinations.

(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows:

(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the

additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6";

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W7";

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W8"; and

(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W9."

(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;

(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and

(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

(2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.

(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.

(3) The following applies for billing and reimbursement of an MMI evaluation.

(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

(ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

(B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:

(i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,

(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

(4) The following applies for billing and reimbursement of an IR evaluation.

(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows.

(I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) $300 for the first musculoskeletal body area; and

(-b-) $150 for each additional musculoskeletal body area.

(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

(v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

(D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and,

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:

(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

(II) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.

(iv) When there is no test to determine an IR for a non-musculoskeletal condition:

(I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.

(II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.

(III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

(5) If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection.

(6) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules,

Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.

(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

(l) The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).

(m) The following shall apply to Treating Doctor Examination to Define the Compensable Injury. When billing for this type of examination, refer to §126.14 of this title (relating to Treating Doctor Examination to Define Compensable Injury).

(n) The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.

(1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs--This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited.

(2) CP, Chronic Pain Management Program--This modifier shall be added to CPT Code 97799 to indicate Chronic Pain Management Program services were performed.

(3) FC, Functional Capacity--This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed.

(4) MR, Outpatient Medical Rehabilitation Program--This modifier shall be added to CPT Code 97799 to indicate Outpatient Medical Rehabilitation Program services were performed.

(5) MI, Multiple Impairment Ratings--This modifier shall be added to CPT Code 99455 when the designated doctor is required to complete multiple impairment ratings calculations.

(6) NM, Not at Maximum Medical Improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.

(7) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC)--This modifier shall be added to CPT Code 99456 when a RTW or EMC examination is performed.

(8) SP, Specialty Area--This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.

(9) TC, Technical Component--This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.

(10) VR, Review report--This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only.

(11) V1, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to a "minimal" level.

(12) V2, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "self limited or minor" level.

(13) V3, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "low to moderate" level.

(14) V4, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration.

(15) V5, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.

(16) WC, Work Conditioning--This modifier shall be added to CPT Code 97545 to indicate work conditioning was performed.

(17) WH, Work Hardening--This modifier shall be added to CPT Code 97545 to indicate work hardening was performed.

(18) WP, Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.

(19) W1, Case Management for Treating Doctor--This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.

(20) W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.

(21) W6, Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury.

(22) W7, Designated Doctor Examination for Disability--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury.

(23) W8, Designated Doctor Examination for Return to Work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.

(24) W9, Designated Doctor Examination for Other Similar Issues--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.

§134.209. Applicability.

(a) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title apply to workers' compensation specific codes, services, and programs provided in the Texas workers' compensation system, other than:

(1) professional medical services described in §134.203 of this title;

(2) prescription drugs or medicine;

(3) dental services;

(4) the facility services of a hospital or other health care facility; and

(5) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

(b) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title apply to workers' compensation specific codes, services, and programs provided on or after September 1, 2016.

(c) If a court of competent jurisdiction holds that any provision of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications that can be given effect without

the invalid provision or application and the provisions of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250 of this title are severable.

(d) When billing for a treating doctor examination to define the compensable injury, refer to §126.14 of this title.

§134.210. Medical Fee Guideline for Workers' Compensation Specific Services.

(a) Specific provisions contained in the Labor Code or division rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent review organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title, which are made on a case-by-case basis, take precedence, in that case only, over any division rules and Medicare payment policies.

(b) Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:

(1) Health care providers shall bill their usual and customary charges using the most current Level I Current Procedural Terminology (CPT) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. Health care providers shall submit medical bills in accordance with the Labor Code and division rules.

(2) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with

Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

(3) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in §§134.220, 134.225, 134.235, 134.240, and 134.250 of this title and subsection (d) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title.

(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(d) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

(e) The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.

(1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs--This modifier shall be used when a health care provider bills for a return to work rehabilitation program that is CARF accredited.

(2) CP, chronic pain management program--This modifier shall be added to CPT code 97799 to indicate chronic pain management program services were performed.

(3) FC, functional capacity--This modifier shall be added to CPT code 97750 when a functional capacity evaluation is performed.

(4) MR, outpatient medical rehabilitation program--This modifier shall be added to CPT code 97799 to indicate outpatient medical rehabilitation program services were performed.

(5) MI, multiple impairment ratings--This modifier shall be added to CPT code 99455 when the designated doctor is required to complete multiple impairment ratings calculations.

(6) NM, not at maximum medical improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.

(7) RE, return to work (RTW) and/or evaluation of medical care (EMC)--This modifier shall be added to CPT code 99456 when a RTW or EMC examination is performed.

(8) SP, specialty area--This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.

(9) TC, technical component--This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.

(10) VR, review report--This modifier shall be added to CPT code 99455 to indicate that the service was the treating doctor's review of report(s) only.

(11) V1, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to a "minimal" level.

(12) V2, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "self limited or minor" level.

(13) V3, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "low to moderate" level.

(14) V4, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "moderate to high severity" level and at least 25 minutes duration.

(15) V5, level of MMI for treating doctor--This modifier shall be added to CPT code 99455 when the office visit level of service is equal to "moderate to high severity" level and at least 45 minutes duration.

(16) WC, work conditioning--This modifier shall be added to CPT code 97545 to indicate work conditioning was performed.

(17) WH, work hardening--This modifier shall be added to CPT code 97545 to indicate work hardening was performed.

(18) WP, whole procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single health care provider.

(19) W1, case management for treating doctor--This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.

(20) W5, designated doctor examination for impairment or attainment of MMI--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of MMI.

(21) W6, designated doctor examination for extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the injured employee's compensable injury.

(22) W7, designated doctor examination for disability--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury.

(23) W8, designated doctor examination for return to work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of injured employee to return to work.

(24) W9, designated doctor examination for other similar issues--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.

§134.215. Home Health Services.

The maximum allowable reimbursement (MAR) amount for home health services provided through a licensed home health agency shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

§134.220. Case Management Services.

Case management responsibilities by the treating doctor are as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

(A) Team members shall not be employees of the treating doctor.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

(B) developing or revising a treatment plan, including any treatment plans required by division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any health care provider that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.

(ii) Reimbursement to the referral health care provider shall be $28 when a health care provider contributes to the case management activity.

(B) CPT code 99362.

(i) Reimbursement to the treating doctor shall be $198. Modifier "W1" shall be added.

(ii) Reimbursement to the referral health care provider shall be $50 when a health care provider contributes to the case management activity.

(C) CPT code 99371.

(i) Reimbursement to the treating doctor shall be $18. Modifier "W1" shall be added.

(ii) Reimbursement to a referral health care provider contributing to this case management activity shall be $5.

(D) CPT code 99372.

(i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added.

(ii) Reimbursement to the referral health care provider contributing to this case management activity shall be $12.

(E) CPT code 99373.

(i) Reimbursement to the treating doctor shall be $90. Modifier "W1" shall be added.

(ii) Reimbursement to the referral health care provider contributing to this case management action shall be $23.

§134.225. Functional Capacity Evaluations.

The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the

discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:

(A) appearance (observational and palpation);

(B) flexibility of the extremity joint or spinal region (usually observational);

(C) posture and deformities;

(D) vascular integrity;

(E) neurological tests to detect sensory deficit;

(F) myotomal strength to detect gross motor deficit; and

(G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:

(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and

(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:

(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);

(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;

(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

(D) static positional tolerance (observational determination of tolerance for sitting or standing).

§134.230. Return to Work Rehabilitation Programs.

The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier.

(1) Accreditation by the CARF is recommended, but not required.

(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below.

The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).

(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

(2) For division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WC." Each additional hour shall be billed using CPT code 97546 with modifier "WC." CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

§134.235. Return to Work/Evaluation of Medical Care.

The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested

RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

§134.239. Billing for Work Status Reports.

When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title.

§134.240. Designated Doctor Examinations.

The following shall apply to designated doctor examinations.

(1) Designated doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules, and shall be billed and reimbursed as follows:

(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W6";

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W7";

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W8"; and

(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier "W9."

(2) When multiple examinations under the same specific division order are performed concurrently under paragraph (1)(C) - (F) of this section:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in §134.235 of this title;

(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in §134.235 of this title; and

(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in §134.235 of this title.

§134.250. Maximum Medical Improvement Evaluations and Impairment Rating Examinations.

Maximum medical improvement (MMI) and/or impairment rating (IR) examinations shall be billed and reimbursed as follows:

(1) The total maximum allowable reimbursement (MAR) for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and

(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.

(2) A health care provider shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Labor Code and Chapter 130 of this title.

(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this section. Modifier "NM" shall be added.

(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this section.

(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this section.

(3) The following applies for billing and reimbursement of an MMI evaluation.

(A) An examining doctor who is the treating doctor shall bill using CPT code 99455 with the appropriate modifier.

(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

(ii) Modifiers "V1," "V2," "V3," "V4," or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

(B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and the referral examining doctor has:

(i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this section; or

(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this section.

(C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350.

(4) The following applies for billing and reimbursement of an IR evaluation.

(A) The health care provider shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(B) When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows:

(I) $150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) $300 for the first musculoskeletal body area; and

(-b-) $150 for each additional musculoskeletal body area.

(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

(iv) If, in accordance with §130.1 of this title, the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

(v) If a health care provider, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the health care provider shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the health care provider must be certified. Reimbursement shall be 20 percent of the total MAR.

(D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:

(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

(II) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.

(iv) When there is no test to determine an IR for a non-musculoskeletal condition:

(I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.

(II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.

(III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

(5) If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this section.

(6) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Labor Code and Chapter 130 of this title. The treating doctor shall bill using CPT code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2016.

_____
Nicholas Canaday III
General Counsel
Texas Department of Insurance, Division of Workers' Compensation

The commissioner adopts amendments to 28 TAC §134.204 and new 28 TAC §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, and 134.250.

_____
W. Ryan Brannan
Commissioner of Workers' Compensation

COMMISSIONER'S ORDER NO._____

ATTEST:

X _____

Nicholas Canaday III
General Counsel
Texas Department of Insurance, Division of Workers' Compensation

COMMISSIONER'S ORDER NO._____