Non Substantive Reorganization of §134.204 Stakeholder Chart

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
Amended 28 TAC §134.204.

Existing 28 TAC §134.204. **(Existing Language)**	**Amended 28 TAC §134.204.** Deleted Text ● Added text ● **(Amended Language)**
§134.204. Medical Fee Guideline for Workers Compensation Specific Services.	**§134.204. Medical Fee Guideline for Workers Compensation Specific Services.**
(a) Applicability of this rule is as follows:	(a) Applicability of this rule is as follows:
(1) No change.	(1) No change.
(2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.	(2) This section applies to workers' compensation specific codes, services and programs provided from[~~on or after~~] March 1, 2008 until September 1, 2016.
(3) – (5) No change.	(3) – (5) No change.
(b) – (n) No change.	(b) – (n) No change.

SUBCHAPTER C. MEDICAL FEE GUIDELINES
New 28 TAC §§134.209 – 134.250.

Existing 28 TAC §134.204. **(Existing Language)**	**New 28 TAC §§134.209 – 134.250.** Deleted Text ● Added text ● **(Adopted Draft Language)**
§134.204. Medical Fee Guideline for Workers Compensation Specific Services.	**New §134.209. Applicability.**
(a) Applicability of this rule is as follows:	[~~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) [~~This~~] Sections [~~section~~] 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[~~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);	(1) 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	(2) prescription drugs or medicine; (3) dental services; (4) 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.	(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.
(2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.	(b) [~~This~~] Sections [~~section~~] 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 [~~applies~~] to workers' compensation specific codes, services, and programs provided on or after September 1, 2016[~~March 1, 2008~~].
N/A	(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.
(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).	(d) [~~The following shall apply to Treating Doctor Examination to Define the Compensable Injury~~]. When billing for a treating doctor[~~this type of~~] examination to define the compensable injury, refer to §126.14 of this title[~~(relating to Treating Doctor Examination to Define Compensable Injury)~~].
	New §134.210. Medical Fee Guideline for Workers Compensation Specific Services.
(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.	[~~(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 theTexas Department of Insurance, Division of Workers' Compensation (Division) rules,	(a) Specific provisions contained in the Labor Code or [~~the~~] division [~~Texas Department of Insurance, Division of Workers' Compensation~~

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 of Medical Necessity Disputes 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.	~~(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[~~Review Organization (IRO)~~]decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title[~~(relating to MDR of Medical Necessity Disputes by Independent Review Organizations)~~],~~-~~which are made on a case-by-case basis, take precedence, in that case only, over any division [~~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:	(b) Payment policies relating[~~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.	(1) [~~Billing.~~] Health care providers [~~(HCPs)~~] shall bill their usual and customary charges using the most current Level I Current Procedural Terminology (CPT [~~codes~~]) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. Health care providers[~~HCPs~~] shall submit medical bills in accordance with the Labor Code and division [~~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.	(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, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division[~~Division~~]-specific modifiers are identified in subsection (e)[~~(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).	(3) [~~Incentive Payments.~~] 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, 134.250 of this title and subsection (d) [~~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.	(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.

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(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:	(d) When there is no negotiated or contracted amount that complies with Labor Code §413.011 [~~of the Labor Code~~], reimbursement shall be the least of the:
(1) MAR amount;	(1) MAR amount;
(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or	(2) health care provider's usual and customary charge, unless directed by division[~~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).	(3) fair and reasonable amount consistent with the standards of §134.1 of this title [~~(relating to Medical Reimbursement)~~].
(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.	(e) The following division modifiers [~~Division Modifiers~~] shall be used by health care providers [~~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.	(1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) accredited [~~Accredited~~] programs--This modifier shall be used when a health care provider [~~HCP~~] bills for a Return to[~~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.	(2) CP, chronic pain management program [~~Chronic Pain Management Program~~]--This modifier shall be added to CPT code[~~Code~~] 97799 to indicate chronic pain management program [~~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.	(3) FC, functional capacity [~~Functional Capacity~~]--This modifier shall be added to CPT code[~~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.	(4) MR, outpatient medical rehabilitation program [~~Outpatient Medical Rehabilitation Program~~]--This modifier shall be added to CPT code[~~Code~~] 97799 to indicate outpatient medical rehabilitation program [~~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.	(5) MI, multiple impairment ratings [~~Multiple Impairment Ratings~~]--This modifier shall be added to CPT code[~~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.	(6) NM, not at maximum medical improvement [~~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	(7) RE, return to work[~~Return to Work~~] (RTW) and/or evaluation[~~Evaluation~~] of medical care[~~Medical Care~~] (EMC)--This modifier shall be

or EMC examination is performed.	added to CPT code[~~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.	(8) SP, specialty area[~~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.	(9) TC, technical component[~~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.	(10) VR, review[~~Review~~] report--This modifier shall be added to CPT code[~~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.	(11) V1, level[~~Level~~] of MMI for treating doctor[~~Treating Doctor~~]--This modifier shall be added to CPT code [~~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.	(12) V2, level[~~Level~~] of MMI for treating doctor[~~Treating Doctor~~]--This modifier shall be added to CPT code [~~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.	(13) V3, level[~~Level~~] of MMI for treating doctor[~~Treating Doctor~~]--This modifier shall be added to CPT code [~~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.	(14) V4, level[~~Level~~] of MMI for treating doctor[~~Treating Doctor~~]--This modifier shall be added to CPT code [~~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.	(15) V5, level[~~Level~~] of MMI for treating doctor[~~Treating Doctor~~]--This modifier shall be added to CPT code[~~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.	(16) WC, work conditioning[~~Work Conditioning~~]--This modifier shall be added to CPT code[~~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.	(17) WH, work hardening[~~Work Hardening~~]—This modifier shall be added to CPT code[~~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.	(18) WP, whole procedure[~~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[~~HCP~~].
(19) W1, Case Management for Treating	(19) W1, case management[~~Case~~

Doctor--This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.	~~Management~~] for treating doctor[~~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.	(20) W5, designated doctor examination [~~Designated Doctor Examination~~] for impairment[~~Impairment~~] or attainment[~~Attainment~~] of MMI[~~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 MMI[~~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.	(21) W6, designated doctor examination [~~Designated Doctor Examination~~] for extent[~~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.	(22) W7, designated doctor examination [~~Designated Doctor Examination~~] for disability[~~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.	(23) W8, designated doctor examination [~~Designated Doctor Examination~~] for return[~~Return~~] to work[~~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.	(24) W9, designated doctor examination [~~Designated Doctor Examination~~] for other similar issues[~~Other Similar Issues~~]--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.
	New §134.215. Home Health Services.
(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.	[~~(f)~~] The maximum allowable reimbursement (MAR)[~~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.
	New §134.220. Case Management Services.
(e) Case Management Responsibilities by the Treating Doctor is as follows:	[~~(e)~~] Case management responsibilities [~~Management Responsibilities~~] by the treating doctor are [~~Treating Doctor is~~] as follows:
(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.	(1) Team conferences and telephone calls shall include coordination with an interdisciplinary

	team.
(A) Team members shall not be employees of the treating doctor.	(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.	(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.	(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:	(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;	(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;	(B) developing or revising a treatment plan, including any treatment plans required by division[~~Division~~] rules;
(C) altering or clarifying previous instructions; or	(C) altering or clarifying previous instructions; or
(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.	(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:	(4) Case management services require the treating doctor to submit documentation that identifies any health care provider[~~HCP~~] that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:
(A) CPT Code 99361.	(A) CPT code[~~Code~~] 99361.
(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.	(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.	(ii) Reimbursement to the referral health care provider[~~HCP~~] shall be $28 when a health care provider[~~HCP~~] contributes to the case management activity.
(B) CPT Code 99362.	(B) CPT code[~~Code~~] 99362.
(i) Reimbursement to the treating doctor shall be $198. Modifier "W1" shall be added.	(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.	(ii) Reimbursement to the referral health care provider[~~HCP~~] shall be $50 when a health care provider [~~HCP~~] contributes to the case management activity
(C) CPT Code 99371.	(C) CPT code[~~Code~~] 99371.
(i) Reimbursement to the treating doctor	(i) Reimbursement to the treating doctor

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shall be $18. Modifier "W1" shall be added.	shall be $18. Modifier "W1" shall be added.
(ii) Reimbursement to a referral HCP contributing to this case management activity shall be $5.	(ii) Reimbursement to a referral health care provider[~~HCP~~] contributing to this case management activity shall be $5.
(D) CPT Code 99372.	(D) CPT code [~~Code~~] 99372.
(i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added.	(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.	(ii) Reimbursement to the referral health care provider[~~HCP~~] contributing to this case management activity shall be $12.
(E) CPT Code 99373.	(E) CPT code [~~Code~~] 99373.
(i) Reimbursement to the treating doctor shall be $90. Modifier "W1" shall be added.	(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.	(ii) Reimbursement to the referral health care provider[~~HCP~~] contributing to this case management action shall be $23.
	New 134.225. Functional Capacity Evaluations.
(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:	[~~(g)~~] The following applies to functional capacity evaluations[~~Functional Capacity Evaluations~~] (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division [~~Division~~] shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code[~~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 [~~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:	(1) A physical examination and neurological evaluation, which include the following:
(A) appearance (observational and palpation);	(A) appearance (observational and palpation);
(B) flexibility of the extremity joint or spinal region (usually observational);	(B) flexibility of the extremity joint or spinal region (usually observational);
(C) posture and deformities;	(C) posture and deformities;
(D) vascular integrity;	(D) vascular integrity;
(E) neurological tests to detect sensory deficit;	(E) neurological tests to detect sensory deficit;
(F) myotomal strength to detect gross motor deficit; and	(F) myotomal strength to detect gross motor deficit; and
(G) reflexes to detect neurological reflex symmetry.	(G) reflexes to detect neurological reflex symmetry.
(2) A physical capacity evaluation of the injured area, which includes the following:	(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	(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.	(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:	(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);	(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;	(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	(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).	(D) static positional tolerance (observational determination of tolerance for sitting or standing).
	New §134.230. Return to Work Rehabilitation Programs.
(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.	[~~(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[~~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.	(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.	(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)[~~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.	(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.	(2) For division [~~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.	(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code[~~Code~~] 97545 with modifier "WC." Each additional hour shall be billed using CPT code[~~Code~~] 97546 with modifier "WC." CARF accredited programs[~~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.	(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.	(3) For division[~~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.	(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code[~~Code~~] 97545 with modifier "WH." Each additional hour shall be billed using CPT code[~~Code~~] 97546 with modifier "WH." CARF accredited programs[~~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.	(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 [~~8~~] minutes and less than 23 minutes.
(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.	(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.	(A) Program shall be billed and reimbursed using CPT code[~~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[~~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.	(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.	(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.	(A) Program shall be billed and reimbursed using CPT code[~~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[~~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.	(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.
	New §134.235. Return to Work/Evaluation of Medical Care.
(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.	[~~(k)~~]The following shall apply to return[~~Return~~] to work [~~Work~~](RTW)/evaluation[~~Evaluation~~] of medical care[~~Medical Care~~] (EMC)examinations [~~Examinations~~]. When conducting a division[~~Division~~] or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code[~~Code~~] 99456 with modifier "RE." In either instance of whether maximum medical improvement/impairment rating (MMI/IR) [~~MMI/IR~~] is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title[~~subsection (i) of this section~~] and shall include division[~~Division~~]-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.
	New §134.239. Billing for Work Status Report.
(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).	[~~(l) The following shall apply to Work Status Reports.~~] When billing for a work status report[~~Work Status Report~~] that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title[~~subsections (i) and (j) of this section~~], refer to §129.5 of this title[~~(relating to Work Status Reports)~~].
	New §134.240. Designated Doctor Examinations.
(i) The following shall apply to Designated Doctor Examinations.	The following shall apply to designated doctor examinations[~~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:	(1) Designated doctors[~~Doctors~~] shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and division [~~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	(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with §134.250 of this title[~~subsection (j) of this section~~], and the use of the additional modifier "W5"

be applied when performed by a designated doctor;	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;	(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title[~~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;"	(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title[~~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;"	(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 [~~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	(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with §134.235 of this title [~~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."	(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 [~~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:	(2) When multiple examinations under the same specific division[~~Division~~] order are performed concurrently under paragraph (1)(C) - (F) of this section[~~subsection~~]:
(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;	(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in §134.235 of this title[~~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	(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in §134.235 of this title[~~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.	(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in §134.235 of this title[~~subsection (k) of this section~~].
	New §134.250. Maximum Medical Improvement/ Impairment Rating Examinations.
(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:	Maximum medical improvement (MMI) [~~Medical Improvement~~] and/or impairment rating (IR)[~~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	(1) The total maximum allowable reimbursement (MAR) [~~MAR~~] for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for

IR. The MMI/IR examination shall include:	the assignment of an IR. The MMI/IR examination shall include:
(A) the examination;	(A) the examination;
(B) consultation with the injured employee;	(B) consultation with the injured employee;
(C) review of the records and films;	(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,	(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).	(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 [~~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.	(2) A health care provider [~~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 Labor Code and [~~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.	(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[~~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.	(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[~~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.	(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[~~subsection~~].
(3) The following applies for billing and reimbursement of an MMI evaluation.	(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.	(A) An examining doctor who is the treating doctor shall bill using CPT code[~~Code~~] 99455 with the appropriate modifier.
(i) Reimbursement shall be the applicable established patient office visit level associated with	(i) Reimbursement shall be the applicable established patient office visit level associated with

the examination.	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.	(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:	(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,	(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 [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.	(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 [subsection].
(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.	(C) An examining doctor, other than the treating doctor, shall bill using CPT code[Code] 99456. Reimbursement shall be $350.
(4) The following applies for billing and reimbursement of an IR evaluation.	(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.	(A) The health care provider[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.	(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.	(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	(I) $150 for each body area if the diagnosis

Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.	related estimates [~~Diagnosis Related Estimates~~] (DRE) method found in the AMA Guides fourth[~~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.	(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.	(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.	(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.	(v) If a health care provider[~~HCP~~], 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[~~HCP~~] shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the health care provider[~~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.	(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	(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:	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.	(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.	(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.	(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.	(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.	(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 [~~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.	(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 [~~Act and Division Rules,~~] Chapter 130 of this title. The treating doctor shall bill using CPT code[~~Code~~] 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.