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.	Amended 28 TAC §134.204.
	Deleted Text Added text
(Existing Language)	(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 <u>from[on or after]</u> March 1, 2008 <u>until September 1, 2016</u> .
(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.	New 28 TAC §§134.209 – 134.250.
	Deleted Text Added text
(Existing Language)	(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'	(a) [This] Sections [section] 134.209, 134.210,
compensation specific codes, services and	<u>134.215, 134.220, 134.225, 134.230, 134.235,</u>
programs provided in the Texas workers'	134.239, 134.240, and 134.250 of this title
compensation system, other than:	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	(1) professional medical services described in
§134.203 of this title (relating to Medical Fee	§134.203 of this title[(relating to Medical Fee
Guideline for Professional Services);	Guideline for Professional Services);

(B) prescription drugs or medicine;	(2) prescription drugs or medicine;
(C) dental services;	(3) dental services;
(D) the facility services of a hospital or other	(4) the facility services of a hospital or other
health care facility; and	health care facility; and
(E) medical services provided through a	(5) medical services provided through a
workers' compensation health care network	workers' compensation health care network certified
certified pursuant to Insurance Code Chapter 1305,	pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance
except as provided in §134.1 of this title and Insurance Code Chapter 1305.	Code Chapter 1305.
(2) This section applies to workers'	(b) [This] Sections [section] 134.209, 134.210,
compensation specific codes, services and	134.215, 134.220, 134.225, 134.230, 134.235,
programs provided on or after March 1, 2008.	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,
	<u>134.220, 134.225, 134.230, 134.235, 134.239,</u> 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,
	<u>134.220, 134.225, 134.230, 134.235, 134.239,</u>
	134.240, and 134.250 of this title are severable.
(m) The following shall apply to Treating Doctor	(d) [The following shall apply to Treating Doctor
Examination to Define the Compensable Injury. When billing for this type of examination, refer to	Examination to Define the Compensable Injury].
§126.14 of this title (relating to Treating Doctor	When billing for <u>a treating doctor</u> [this type of] examination to define the compensable injury, refer
Examination to Define Compensable Injury).	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,	[(3) For workers' compensation specific codes,
services and programs provided between August	services and programs provided between August 1,
1, 2003 and March 1, 2008, §134.202 of this title	2003 and March 1, 2008, §134.202 of this title
(relating to Medical Fee Guideline) applies.	(relating to Medical Fee Guideline) applies.]
(4) For workers' compensation specific codes,	[(4) For workers' compensation specific codes,
services and programs provided prior to August 1,	services and programs provided prior to August 1,
2003, §134.201 of this title (relating to Medical Fee	2003, §134.201 of this title (relating to Medical Fee
Guideline for Medical Treatments and Services	Guideline for Medical Treatments and Services
Provided under the Texas Workers' Compensation	Provided under the Texas Workers' Compensation
Act) and §134.302 of this title (relating to Dental	Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.]
Fee Guideline) apply. (5) Specific provisions contained in the Labor	(a) Specific provisions contained in the Labor
Code or theTexas Department of Insurance,	Code or [the] division [Texas Department of
Division of Workers' Compensation (Division) rules,	Insurance, Division of Workers' Compensation
	incuration, principal of trainers bompenoution

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 <u>review organization</u> [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 <u>policies relating</u> [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 <u>Current Procedural</u> <u>Terminology</u> (CPT [codes]) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. <u>Health care providers</u> [HCPs] shall submit medical bills in accordance with the Labor Code and <u>division</u> [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, <u>insurance</u> carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, <u>division</u> [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.

(d) When there is no negotiated or contracted	(d) When there is no negotiated or contracted
amount that complies with §413.011 of the Labor	amount that complies with Labor Code §413.011 [of
Code, reimbursement shall be the least of the:	the Labor Code], reimbursement shall be the least
	of the:
(1) MAR amount;	(1) MAR amount;
(2) health care provider's usual and customary	(2) health care provider's usual and customary
charge, unless directed by Division rule to bill a	charge, unless directed by division[Division] rule to
specific amount; or	bill a specific amount; or
(3) fair and reasonable amount consistent with	(3) fair and reasonable amount consistent with
the standards of §134.1 of this title (relating to	the standards of §134.1 of this title [(relating to
Medical Reimbursement).	Medical Reimbursement)].
(n) The following Division Modifiers shall be used	(e) The following division modifiers [Division
by HCPs billing professional medical services for	Modifiers] shall be used by health care providers
correct coding, reporting, billing, and	[HCPs] billing professional medical services for
reimbursement of the procedure codes.	correct coding, reporting, billing, and reimbursement
reinbursement of the procedure codes.	
(1) CA Commission on Appreditation of	of the procedure codes.
(1) CA, Commission on Accreditation of	(1) CA, Commission on Accreditation of
Rehabilitation Facilities (CARF) Accredited	Rehabilitation Facilities (CARF) <u>accredited</u>
programsThis modifier shall be used when a HCP	[Accredited] programsThis modifier shall be used
bills for a Return To Work Rehabilitation Program	when a health care provider [HCP] bills for a Return
that is CARF accredited.	to[To] Work Rehabilitation Program that is CARF
	accredited.
(2) CP, Chronic Pain Management Program—	(2) CP, chronic pain management program
This modifier shall be added to CPT Code 97799 to	[Chronic Pain Management Program]This modifier
indicate Chronic Pain Management Program	shall be added to CPT <u>code</u> [Code] 97799 to indicate
services were performed.	chronic pain management program Chronic Pain
	Management Program] services were performed.
(3) FC, Functional CapacityThis modifier shall	(3) FC, functional capacity [Functional
be added to CPT Code 97750 when a functional	Capacity]This modifier shall be added to CPT
capacity evaluation is performed.	code[Code] 97750 when a functional capacity
	evaluation is performed.
(4) MR, Outpatient Medical Rehabilitation	(4) MR, outpatient medical rehabilitation
ProgramThis modifier shall be added to CPT	program (Outpatient Medical Rehabilitation
Code 97799 to indicate Outpatient Medical	Program]This modifier shall be added to CPT
Rehabilitation Program services were performed.	code[Code] 97799 to indicate outpatient medical
······································	rehabilitation program [Outpatient Medical
	Rehabilitation Program [services were performed.
(5) MI, Multiple Impairment Ratings—This	(5) MI, multiple impairment ratings [Multiple
modifier shall be added to CPT Code 99455 when	Impairment Ratings]This modifier shall be added
the designated doctor is required to complete	to CPT <u>code</u> [Code] 99455 when the designated
multiple impairment ratings calculations.	
	doctor is required to complete multiple impairment
(6) NM. Not at Maximum Madiaal Improvement	ratings calculations.
(6) NM, Not at Maximum Medical Improvement	(6) NM, <u>not at maximum medical improvement</u>
(MMI)This modifier shall be added to the	[Not at Maximum Medical Improvement] (MMI)This
appropriate MMI CPT code to indicate that the	modifier shall be added to the appropriate MMI CPT
injured employee has not reached MMI when the	code to indicate that the injured employee has not
purpose of the examination was to determine MMI.	reached MMI when the purpose of the examination
	was to determine MMI.
(7) RE, Return to Work (RTW) and/or	(7) RE, <u>return to work</u> [Return to Work] (RTW)
Evaluation of Medical Care (EMC)This modifier	and/or evaluation[Evaluation] of medical
shall be added to CPT Code 99456 when a RTW	<pre>care[Medical Care] (EMC)This modifier shall be</pre>

or EMC examination is performed.	added to CPT code[Code] 99456 when a RTW or
·	EMC examination is performed.
(8) SP, Specialty AreaThis modifier shall be	(8) SP, <u>specialty area[Specialty Area</u>]—This
added to the appropriate MMI CPT code when a	modifier shall be added to the appropriate MMI CPT
specialty area is incorporated into the MMI report.	code when a specialty area is incorporated into the
	MMI report.
(9) TC, Technical ComponentThis modifier	(9) TC, technical component Technical
shall be added to the CPT code when the technical	Component]This modifier shall be added to the
component of a procedure is billed separately.	CPT code when the technical component of a
	procedure is billed separately.
(10) VR, Review reportThis modifier shall be	(10) VR, <u>review</u> [Review] reportThis modifier
added to CPT Code 99455 to indicate that the	shall be added to CPT <u>code[Code</u>] 99455 to indicate
service was the treating doctor's review of report(s)	that the service was the treating doctor's review of
only.	report(s) only.
(11) V1, Level of MMI for Treating Doctor—This	(11) V1, level[Level] of MMI for treating
modifier shall be added to CPT Code 99455 when	doctor[Treating Doctor]This modifier shall be
the office visit level of service is equal to a	added to CPT code [Code] 99455 when the office
"minimal" level.	visit level of service is equal to a "minimal" level.
(12) V2, Level of MMI for Treating Doctor—This	(12) V2, level[Level] of MMI for treating
modifier shall be added to CPT Code 99455 when	doctor[Treating Doctor]This modifier shall be
the office visit level of service is equal to "self	added to CPT code [Code] 99455 when the office
limited or minor" level.	visit level of service is equal to "self limited or minor"
	level.
(13) V3, Level of MMI for Treating Doctor—This	(13) V3, level[Level] of MMI for treating
modifier shall be added to CPT Code 99455 when	doctor[Treating Doctor]This modifier shall be
the office visit level of service is equal to "low to	added to CPT code [Code] 99455 when the office
moderate" level.	visit level of service is equal to "low to moderate"
	level.
(14) V4, Level of MMI for Treating Doctor—This	(14) V4, level[Level] of MMI for treating
modifier shall be added to CPT Code 99455 when	doctor[Treating Doctor]This modifier shall be
the office visit level of service is equal to "moderate	added to CPT code [Code] 99455 when the office
to high severity" level and of at least 25 minutes	visit level of service is equal to "moderate to high
duration.	severity" level and [of] at least 25 minutes duration.
(15) V5, Level of MMI for Treating Doctor—This	(15) V5, level[Level] of MMI for treating
modifier shall be added to CPT Code 99455 when	doctor[Treating Doctor]This modifier shall be
the office visit level of service is equal to "moderate	added to CPT code[Code] 99455 when the office
to high severity" level and of at least 45 minutes	visit level of service is equal to "moderate to high
duration.	severity" level and [of] at least 45 minutes duration.
(16) WC, Work ConditioningThis modifier shall	(16) WC, work conditioning
be added to CPT Code 97545 to indicate work	Conditioning]This modifier shall be added to CPT
conditioning was performed.	code[Code] 97545 to indicate work conditioning was
	performed.
(17) WH, Work HardeningThis modifier shall	(17) WH, work hardening[Work Hardening]-
be added to CPT Code 97545 to indicate work	This modifier shall be added to CPT code[Code]
hardening was performed.	97545 to indicate work hardening was performed.
(18) WP, Whole ProcedureThis modifier shall	(18) WP, whole procedure[Whole
be added to the CPT code when both the	<u>Procedure</u>]—This modifier shall be added to the
professional and technical components of a	CPT code when both the professional and technical
procedure are performed by a single HCP.	components of a procedure are performed by a
procedure are performed by a single rior.	single health care provider[HCP].
(19) W1, Case Management for Treating	(19) W1, <u>case management</u> [Case
	(13) WT, Case management base

DoctorThis 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(20) W5, designated doctor examination [Designated Doctor Examination] for
activities when performed by the treating doctor.management billing code activities when performed by the treating doctor.(20) W5, Designated Doctor Examination for(20) W5, designated doctor examination
by the treating doctor. (20) W5, Designated Doctor Examination for (20) W5, designated doctor examination
(20) W5, Designated Doctor Examination for (20) W5, designated doctor examination
ImprovementThis modifier shall be added to the impairment[Impairment] or attainment[Attainment] of
appropriate examination code performed by a <u>MMI[Maximum Medical Improvement]</u> This modifier
designated doctor when determining impairment shall be added to the appropriate examination code
caused by the compensable injury and in performed by a designated doctor when determining
attainment of maximum medical improvement.
in attainment of MMI[maximum medical
improvement].
(21) W6, Designated Doctor Examination for (21) W6, <u>designated doctor examination</u>
Extent-This modifier shall be added to the [Designated Doctor Examination] for extent[Extent]
appropriate examination code performed by a This modifier shall be added to the appropriate
designated doctor when determining extent of the examination code performed by a designated doctor
employee's compensable injury. when determining extent of the injured employee's
compensable injury.
(22) W7, Designated Doctor Examination for (22) W7, <u>designated doctor examination</u>
DisabilityThis modifier shall be added to the [Designated Doctor Examination] for
appropriate examination code performed by a <u>disability</u> [Disability]This modifier shall be added to
designated doctor when determining whether the the appropriate examination code performed by a
injured employee's disability is a direct result of the designated doctor when determining whether the
work-related injury.
work-related injury.
(23) W8, Designated Doctor Examination for (23) W8, <u>designated doctor examination</u>
Return to WorkThis modifier shall be added to the [Designated Doctor Examination] for return[Return]
appropriate examination code performed by a to work [Work]This modifier shall be added to the
designated doctor when determining the ability of appropriate examination code performed by a
employee to return to work. designated doctor when determining the ability of
injured employee to return to work.
(24) W9, Designated Doctor Examination for (24) W9, designated doctor examination
Other Similar IssuesThis modifier shall be added [Designated Doctor Examination] for other similar
to the appropriate examination code performed by issues[Other Similar Issues]This modifier shall be
a designated doctor when determining other similar added to the appropriate examination code
issues. 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 [(f)] The maximum allowable reimbursement
services provided through a licensed home health (MAR)[To determine the MAR] amount for home
agency, the MAR shall be 125 percent of the health services provided through a licensed home
published Texas Medicaid fee schedule for home health agency[, the MAR] shall be 125 percent of
health agencies. the published Texas Medicaid fee schedule for
home health agencies.
New §134.220. Case Management Services.
(e) Case Management Responsibilities by the [(e)] Case <u>management responsibilities</u>
Treating Doctor is as follows: [Management Responsibilities] by the treating
doctor are [Treating Doctor is] as follows:
(1) Team conferences and telephone calls shall (1) Team conferences and telephone calls
include coordination with an interdisciplinary team. shall include coordination with an interdisciplinary

	team.
(A) Team members shall not be employees of	(A) Team members shall not be employees
the treating doctor. (B) Team conferences and telephone calls	of the treating doctor. (B) Team conferences and telephone calls
must be outside of an interdisciplinary program.	must be outside of an interdisciplinary program.
Documentation shall include the purpose and	Documentation shall include the purpose and
outcome of conferences and telephone calls, and	outcome of conferences and telephone calls, and
the name and specialty of each individual attending	the name and specialty of each individual attending
the team conference or engaged in a phone call.	the team conference or engaged in a phone call.
(2) Team conferences and telephone calls	(2) Team conferences and telephone calls
should be triggered by a documented change in	should be triggered by a documented change in the
the condition of the injured employee and	condition of the injured employee and performed for
performed for the purpose of coordination of	the purpose of coordination of medical treatment
medical treatment and/or return to work for the	and/or return to work for the injured employee.
injured employee.	
(3) Contact with one or more members of the	(3) Contact with one or more members of the
interdisciplinary team more often than once every	interdisciplinary team more often than once every
30 days shall be limited to the following:	30 days shall be limited to the following:
(A) coordinating with the employer, employee,	(A) coordinating with the employer,
or an assigned medical or vocational case	employee, or an assigned medical or vocational
manager to determine return to work options;	case manager to determine return to work options;
(B) developing or revising a treatment plan,	(B) developing or revising a treatment plan,
including any treatment plans required by Division	including any treatment plans required by
rules;	division[Division] rules;
(C) altering or clarifying previous instructions;	(C) altering or clarifying previous instructions;
or	or
(D) coordinating the care of employees with	(D) coordinating the care of employees with
catastrophic or multiple injuries requiring multiple	catastrophic or multiple injuries requiring multiple
specialties.	specialties.
(4) Case management services require the	(4) Case management services require the
treating doctor to submit documentation that	treating doctor to submit documentation that
identifies any HCP that contributes to the case	identifies any health care provider[HCP] that
management activity. Case management services	contributes to the case management activity. Case
shall be billed and reimbursed as follows:	management services shall be billed and
	reimbursed as follows:
(A) CPT Code 99361.	(A) CPT <u>code[Code]</u> 99361.
(i) Reimbursement to the treating doctor	(i) Reimbursement to the treating doctor
shall be \$113. Modifier "W1" shall be added.	shall be \$113. Modifier "W1" shall be added.
(ii) Reimbursement to the referral HCP shall	(ii) Reimbursement to the referral <u>health</u>
be \$28 when a HCP contributes to the case	care provider[HCP] shall be \$28 when a health care
management activity.	provider[HCP] contributes to the case management
	activity.
(B) CPT Code 99362.	(B) CPT <u>code[Code]</u> 99362.
(i) Reimbursement to the treating doctor	(i) Reimbursement to the treating doctor
shall be \$198. Modifier "W1" shall be added.	shall be \$198. Modifier "W1" shall be added.
(ii) Reimbursement to the referral HCP shall	(ii) Reimbursement to the referral health
be \$50 when a HCP contributes to the case	<u>care provider[HCP]</u> shall be \$50 when a <u>health care</u>
management activity.	provider [HCP] contributes to the case management
	activity
(C) CPT Code 99371.	(C) CPT <u>code</u> [Code] 99371.
(i) Reimbursement to the treating doctor	(i) Reimbursement to the treating doctor

shall be \$18. Modifier "W1" shall be added.	shall be \$18. Modifier "W1" shall be added.
(ii) Reimbursement to a referral HCP	(ii) Reimbursement to a referral <u>health care</u>
contributing to this case management activity shall	provider[HCP] contributing to this case management
be \$5.	activity shall be \$5.
(D) CPT Code 99372.	(D) CPT <u>code</u> [Code] 99372.
(i) Reimbursement to the treating doctor	(i) Reimbursement to the treating doctor
shall be \$46. Modifier "W1" shall be added.	shall be \$46. Modifier "W1" shall be added.
(ii) Reimbursement to the referral HCP	(ii) Reimbursement to the referral health
contributing to this case management activity shall	care provider[HCP] contributing to this case
be \$12.	management activity shall be \$12.
(E) CPT Code 99373.	(E) CPT <u>code</u> [Code] 99373.
(i) Reimbursement to the treating doctor	(i) Reimbursement to the treating doctor
shall be \$90. Modifier "W1" shall be added.	shall be \$90. Modifier "W1" shall be added.
(ii) Reimbursement to the referral HCP	(ii) Reimbursement to the referral health
contributing to this case management action shall	care provider[HCP] contributing to this case
be \$23.	management action shall be \$23.
	New 134.225. Functional Capacity Evaluations.
(g) The following applies to Functional Capacity	[(g)] The following applies to <u>functional capacity</u>
Evaluations (FCEs). A maximum of three FCEs for	evaluations[Functional Capacity Evaluations]
each compensable injury shall be billed and	(FCEs). A maximum of three FCEs for each
reimbursed. FCEs ordered by the Division shall not	compensable injury shall be billed and reimbursed.
count toward the three FCEs allowed for each	FCEs ordered by the <u>division</u> [Division] shall not
compensable injury. FCEs shall be billed using	count toward the three FCEs allowed for each
CPT Code 97750 with modifier "FC." FCEs shall be	compensable injury. FCEs shall be billed using
reimbursed in accordance with §134.203(c)(1) of	CPT <u>code</u> [Code] 97750 with modifier "FC." FCEs
this title. Reimbursement shall be for up to a	shall be reimbursed in accordance with
maximum of four hours for the initial test or for a	134.203(c)(1) of this title. Reimbursement shall be
Division ordered test; a maximum of two hours for	for up to a maximum of four hours for the initial test
an interim test; and, a maximum of three hours for	or for a <u>division</u> [Division] ordered test; a maximum
the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the	of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the
following elements:	initial test. Documentation is required. FCEs shall
Tonowing elements.	include the following elements:
(1) A physical examination and neurological	(1) A physical examination and neurological
evaluation, which include the following:	evaluation, which include the following:
(A) appearance (observational and palpation);	(A) appearance (observational and palpation);
(B) flexibility of the extremity joint or spinal	(B) flexibility of the extremity joint or spinal
region (usually observational);	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	(F) myotomal strength to detect gross motor
deficit; and	deficit; and
(G) reflexes to detect neurological reflex	(G) reflexes to detect neurological reflex
symmetry.	symmetry.
(2) A physical capacity evaluation of the injured	(2) A physical capacity evaluation of the injured
area, which includes the following:	area, which includes the following:
(A) range of motion (quantitative	(A) range of motion (quantitative
measurements using appropriate devices) of the injured joint or region; and	measurements using appropriate devices) of the injured joint or region; and
ווועובע וטווג טו ופטוטו, מוע	ווויוידים אוויג או זפאוטוו, מווע

TITLE 28. INSURANCE

Part 2. Texas Department of Insurance

Division of Workers' Compensation

Chapter 134. Benefits-Guidelines for Medical Services, Charges and Payments

(B) strength/endurance (quantitative	(B) strength/endurance (quantitative measures
measures using accurate devices) with comparison	using accurate devices) with comparison to
to contralateral side or normative database. This	contralateral side or normative database. This
testing may include isometric, isokinetic, or	testing may include isometric, isokinetic, or
isoinertial devices in one or more planes.	isoinertial devices in one or more planes.
(3) Functional abilities tests, which include the	(3) Functional abilities tests, which include the
following:	following:
(A) activities of daily living (standardized tests	(A) activities of daily living (standardized tests
of generic functional tasks such as pushing,	of generic functional tasks such as pushing, pulling,
pulling, kneeling, squatting, carrying, and climbing);	kneeling, squatting, carrying, and climbing);
(B) hand function tests that measure fine and	(B) hand function tests that measure fine and
gross motor coordination, grip strength, pinch	gross motor coordination, grip strength, pinch
strength, and manipulation tests using measuring	strength, and manipulation tests using measuring
devices;	devices;
(C) submaximal cardiovascular endurance	(C) submaximal cardiovascular endurance
tests which measure aerobic capacity using	tests which measure aerobic capacity using
stationary bicycle or treadmill; and	stationary bicycle or treadmill; and
(D) static positional tolerance (observational	(D) static positional tolerance (observational
determination of tolerance for sitting or standing).	determination of tolerance for sitting or standing).
	New §134.230. Return to Work Rehabilitation
	Programs.
(h) The following shall be applied to Return To	[(h)]The following shall be applied to Return To
Work Rehabilitation Programs for billing and	Work Rehabilitation Programs for billing and
reimbursement of Work Conditioning/General	reimbursement of Work Conditioning/General
Occupational Rehabilitation Programs, Work	Occupational Rehabilitation Programs, Work
Hardening/Comprehensive Occupational	Hardening/Comprehensive Occupational
Rehabilitation Programs, Chronic Pain	Rehabilitation Programs, Chronic Pain
Management/Interdisciplinary Pain Rehabilitation	Management/Interdisciplinary Pain Rehabilitation
Programs, and Outpatient Medical Rehabilitation	Programs, and Outpatient Medical Rehabilitation
Programs. To qualify as a Division Return to Work	Programs. To qualify as a <u>division[Division</u>] Return
Rehabilitation Program, a program should meet the	to Work Rehabilitation Program, a program should
specific program standards for the program as	meet the specific program standards for the
listed in the most recent Commission on	program as listed in the most recent Commission on
Accreditation of Rehabilitation Facilities (CARF)	Accreditation of Rehabilitation Facilities (CARF)
Medical Rehabilitation Standards Manual, which	Medical Rehabilitation Standards Manual, which
includes active participation in recovery and return	includes active participation in recovery and return
to work planning by the injured employee,	to work planning by the injured employee, employer
employer and payor or carrier.	and payor or <u>insurance</u> carrier.
(1) Accreditation by the CARF is recommended,	(1) Accreditation by the CARF is recommended,
but not required.	but not required.
(A) If the program is CARF accredited,	(A) If the program is CARF accredited, modifier
modifier "CA" shall follow the appropriate program	"CA" shall follow the appropriate program modifier
modifier as designated for the specific programs	as designated for the specific programs listed
listed below. The hourly reimbursement for a CARF	below. The hourly reimbursement for a CARF
accredited program shall be 100 percent of the	accredited program shall be 100 percent of the
MAR.	maximum allowable reimbursement (MAR)[MAR].
(B) If the program is not CARF accredited, the	(B) If the program is not CARF accredited, the
only modifier required is the appropriate program	only modifier required is the appropriate program
modifier. The hourly reimbursement for a non-	modifier. The hourly reimbursement for a non-CARF
CARF accredited program shall be 80 percent of	accredited program shall be 80 percent of the MAR.
the MAR.	

(2) For Division purposes, General	(2) For <u>division</u> [Division] purposes, General
Occupational Rehabilitation Programs, as defined	Occupational Rehabilitation Programs, as defined in
in the CARF manual, are considered Work	the CARF manual, are considered Work
Conditioning.	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 <u>code[Code]</u> 97545 with modifier "WC." Each additional hour shall be billed using CPT <u>code[Code]</u> 97546 with modifier "WC." CARF accredited <u>programs[Programs]</u> 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 	 (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[Division] purposes, Comprehensive Occupational Rehabilitation
in the CARF manual, are considered Work	Programs, as defined in the CARF manual, are
Hardening.	considered Work Hardening.
(A) The first two hours of each session shall	(A) The first two hours of each session shall be
be billed and reimbursed as one unit, using CPT	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.	<u>code</u> [Code] 97545 with modifier "WH." Each additional hour shall be billed using CPT <u>code</u> [Code] 97546 with modifier "WH." CARF accredited <u>programs</u> [Programs] shall add "CA" as a second modifier.
(B) Reimbursement shall be \$64 per hour.	(B) Reimbursement shall be \$64 per hour.
Units of less than one hour shall be prorated by 15	Units of less than one hour shall be prorated by 15
minute increments. A single 15 minute increment	minute increments. A single 15 minute increment
may be billed and reimbursed if greater than or	may be billed and reimbursed if greater than or
equal to 8 minutes and less than 23 minutes.	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. (A) Program shall be billed and reimbursed 	 (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.	using CPT <u>code</u> [Code] 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited <u>programs</u> [Programs] shall add "CA" as a second modifier.
(B) Reimbursement shall be \$90 per hour.	(B) Reimbursement shall be \$90 per hour.
Units of less than one hour shall be prorated by 15	Units of less than one hour shall be prorated by 15
minute increments. A single 15 minute increment	minute increments. A single 15 minute increment
may be billed and reimbursed if greater than or	may be billed and reimbursed if greater than or
equal to eight minutes and less than 23 minutes.	equal to eight minutes and less than 23 minutes.
(5) The following shall be applied for billing and	(5) The following shall be applied for billing and
reimbursement of Chronic Pain	reimbursement of Chronic Pain
Management/Interdisciplinary Pain Rehabilitation	Management/Interdisciplinary Pain Rehabilitation
Programs.	Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each	(A) Program shall be billed and reimbursed using CPT code[Code] 97799 with modifier "CP" for
hour. The number of hours shall be indicated in the	each hour. The number of hours shall be indicated
units column on the bill. CARF accredited	in the units column on the bill. CARF accredited
Programs shall add "CA" as a second modifier.	programs[Programs] shall add "CA" as a second
	modifier.
(B) Reimbursement shall be \$125 per hour.	(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	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	may be billed and reimbursed if greater than or
equal to eight minutes and less than 23 minutes.	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	[(k)]The following shall apply to return[Return] to
(RTW) and/or Evaluation of Medical Care (EMC)	work [Work](RTW)/evaluation[Evaluation] of medical
Examinations. When conducting a Division or	care[Medical Care] (EMC)examinations
insurance carrier requested RTW/EMC	[Examinations]. When conducting a
examination, the examining doctor shall bill and be	division[Division] or insurance carrier requested
reimbursed using CPT Code 99456 with modifier	RTW/EMC examination, the examining doctor shall
"RE." In either instance of whether MMI/IR is	bill and be reimbursed using CPT <u>code</u> [Code]
performed or not, the reimbursement shall be \$500	99456 with modifier "RE." In either instance of
in accordance with subsection (i) of this section and shall include Division-required reports. Testing	whether <u>maximum medical improvement/impairment</u> rating (MMI/IR) [MMI/IR] is performed or not, the
that is required shall be billed using the appropriate	reimbursement shall be \$500 in accordance with
CPT codes and reimbursed in addition to the	§134.240 of this title[subsection (i) of this section]
examination fee.	and shall include <u>division</u> [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.
(I) The following shall apply to Work Status	(I) The following shall apply to Work Status
Reports. When billing for a Work Status Report that	Reports.] When billing for a work status report[Work
is not conducted as a part of the examinations	Status Report] that is not conducted as a part of the
outlined in subsections (i) and (j) of this section,	examinations outlined in <u>§134.240 and §134.250 of</u>
refer to §129.5 of this title (relating to Work Status	this title[subsections (i) and (j) of this section], refer
Reports).	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	The following shall apply to <u>designated doctor</u>
Examinations.	examinations[Designated Doctor Examinations].
(1) Designated Doctors shall perform	(1) Designated <u>doctors</u> [Doctors] shall perform
examinations in accordance with Labor Code	examinations in accordance with Labor Code
§§408.004, 408.0041 and 408.151 and Division	§§408.004, 408.0041 and 408.151 and <u>division</u>
rules, and shall be billed and reimbursed as follows:	[Division] rules, and shall be billed and reimbursed as follows:
(A) Impairment caused by the compensable	(A) Impairment caused by the compensable
injury shall be billed and reimbursed in accordance	injury shall be billed and reimbursed in accordance
with subsection (j) of this section, and the use of	with §134.250 of this title[subsection (j) of this
the additional modifier "W5" is the first modifier to	section], and the use of the additional modifier "W5"

be applied when performed by a designated	is the first modifier to be applied when performed by
doctor:	a designated doctor;
(B) Attainment of maximum medical	(B) Attainment of maximum medical
improvement shall be billed and reimbursed in	improvement shall be billed and reimbursed in
accordance with subsection (j) of this section, and	accordance with <u>§134.250 of this title</u> [subsection (j)
the use of the additional modifier "W5" is the first	of this section], and the use of the additional
modifier to be applied when performed by a	modifier "W5" is the first modifier to be applied when
designated doctor;	performed by a designated doctor;
(C) Extent of the employee's compensable	(C) Extent of the employee's compensable
injury shall be billed and reimbursed in accordance	injury shall be billed and reimbursed in accordance
with subsection (k) of this section, with the use of	with §134.235 of this title[subsection (k) of this
the additional modifier "W6;"	section], with the use of the additional modifier
	"W6;"
(D) Whether the injured employee's disability	(D) Whether the injured employee's disability is
is a direct result of the work-related injury shall be	a direct result of the work-related injury shall be
billed and reimbursed in accordance with	billed and reimbursed in accordance with §134.235
subsection (k) of this section, with the use of the	of this title [subsection (k) of this section], with the
additional modifier "W7;"	use of the additional modifier "W7;"
(E) Ability of the employee to return to work	(E) Ability of the employee to return to work
shall be billed and reimbursed in accordance with	shall be billed and reimbursed in accordance with
subsection (k) of this section, with the use of the	§134.235 of this title [subsection (k) of this section],
additional modifier "W8"; and	with the use of the additional modifier "W8"; and
(F) Issues similar to those described in	(F) Issues similar to those described in
subparagraphs (A) - (E) of this paragraph shall be	subparagraphs (A) - (E) of this paragraph shall be
billed and reimbursed in accordance with	billed and reimbursed in accordance with <u>§134.235</u>
subsection (k) of this section, with the use of the	of this title [subsection (k) of this section], with the
additional modifier "W9."	use of the additional modifier "W9."
(2) When multiple examinations under the same	(2) When multiple examinations under the same
specific Division order are performed concurrently	specific division[Division] order are performed
under paragraph (1)(C) - (F) of this subsection:	concurrently under paragraph (1)(C) - (F) of this
	section[subsection]:
(A) the first examination shall be reimbursed	(A) the first examination shall be reimbursed at
at 100 percent of the set fee outlined in subsection	100 percent of the set fee outlined in <u>§134.235 of</u>
(k) of this section;	this title[subsection (k) of this section];
(B) the second examination shall be	(B) the second examination shall be
reimbursed at 50 percent of the set fee outlined in	reimbursed at 50 percent of the set fee outlined in
subsection (k) of this section; and	<u>§134.235 of this title</u> [subsection (k) of this section];
(C) subsequent examinations shall be	and (C) subsequent examinations shall be
(C) subsequent examinations shall be	(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in
reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.	§134.235 of this title[subsection (k) of this section].
	<u>§134.235 of this title</u> subsection (k) of this section. New §134.250. Maximum Medical Improvement/
	Impairment Rating Examinations.
(j) Maximum Medical Improvement and/or	Maximum medical improvement (MMI)
Impairment Rating (MMI/IR) examinations shall be	[Medical Improvement] and/or impairment rating
billed and reimbursed as follows:	(IR)[Impairment Rating (MMI/IR)] examinations shall
	be billed and reimbursed as follows:
(1) The total MAR for an MMI/IR examination	(1) The total maximum allowable reimbursement
shall be equal to the MMI evaluation	(MAR) [MAR] for an MMI/IR examination shall be
reimbursement plus the reimbursement for the	equal to the MMI evaluation reimbursement plus the
body area(s) evaluated for the assignment of an	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	(D) the preparation and submission of reports
(including the narrative report, and responding to	(including the narrative report, and responding to
the need for further clarification, explanation, or	the need for further clarification, explanation, or
reconsideration), calculation tables, figures, and	reconsideration), calculation tables, figures, and
worksheets; and,	worksheets; and $[_{7}]$
(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent	(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	Impairment (AMA Guides), as stated in the Labor
Division rules in Chapter 130 of this title (relating to	Code and [Act and Division rules in] Chapter 130 of
Impairment and Supplemental Income Benefits).	this title[(relating to Impairment and Supplemental
	Income Benefits)].
(2) An HCP shall only bill and be reimbursed for	(2) <u>A health care provider</u> [An HCP] shall only bill
an MMI/IR examination if the doctor performing the	and be reimbursed for an MMI/IR examination if the
evaluation (i.e., the examining doctor) is an	doctor performing the evaluation (i.e., the examining
authorized doctor in accordance with the Act and	doctor) is an authorized doctor in accordance with
Division rules in Chapter 130 of this title.	the Labor Code and [Act and Division rules in]
(A) If the exemining dector, other then the	Chapter 130 of this title.
(A) If the examining doctor, other than the treating doctor, determines MMI has not been	(A) If the examining doctor, other than the treating doctor, determines MMI has not been
reached, the MMI evaluation portion of the	reached, the MMI evaluation portion of the
examination shall be billed and reimbursed in	examination shall be billed and reimbursed in
accordance with paragraph (3) of this subsection.	accordance with paragraph (3) of this
Modifier "NM" shall be added.	section[subsection]. Modifier "NM" shall be added.
(B) If the examining doctor determines MMI	(B) If the examining doctor determines MMI
has been reached and there is no permanent	has been reached and there is no permanent
impairment because the injury was sufficiently	impairment because the injury was sufficiently
minor, an IR evaluation is not warranted and only	minor, an IR evaluation is not warranted and only
the MMI evaluation portion of the examination shall	the MMI evaluation portion of the examination shall
be billed and reimbursed in accordance with	be billed and reimbursed in accordance with
paragraph (3) of this subsection.	paragraph (3) of this <u>section[subsection]</u> . (C) If the examining doctor determines MMI
(C) If the examining doctor determines MMI has been reached and an IR evaluation is	has been reached and an IR evaluation is
performed, both the MMI evaluation and the IR	performed, both the MMI evaluation and the IR
evaluation portions of the examination shall be	evaluation portions of the examination shall be billed
billed and reimbursed in accordance with	and reimbursed in accordance with paragraphs (3)
paragraphs (3) and (4) of this subsection.	and (4) of this section[subsection].
(3) The following applies for billing and	(3) The following applies for billing and
reimbursement of an MMI evaluation.	reimbursement of an MMI evaluation.
(A) An examining doctor who is the treating	(A) An examining doctor who is the treating
doctor shall bill using CPT Code 99455 with the	doctor shall bill using CPT <u>code</u> [Code] 99455 with
appropriate modifier.	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
בסומטווסווכע למופות טוווכב אסור ובעבו מססטנומובע אוווו	องเฉมาเอกอน patient บทบอ ขางเปลี่ยงอา สรรบปลเอน Willi

the examination.	the examination.
(ii) Modifiers "V1", "V2", "V3", "V4", or "V5"	(ii) Modifiers "V1, "[7] "V2, "[7] "V3, "[7] "V4, "[7] or
shall be added to the CPT code to correspond with	"V5" shall be added to the CPT code to correspond
the last digit of the applicable office visit.	with the last digit of the applicable office visit.
(B) If the treating doctor refers the injured	(B) If the treating doctor refers the injured
employee to another doctor for the examination	employee to another doctor for the examination and
and certification of MMI (and IR); and, the referral	certification of MMI (and IR); and[,] the referral
examining doctor has:	examining doctor has:
(i) previously been treating the injured	(i) previously been treating the
employee, then the referral doctor shall bill the MMI	injured employee, then the referral doctor shall bill
evaluation in accordance with paragraph (3)(A) of	the MMI evaluation in accordance with paragraph
this subsection; or,	(3)(A) of this <u>section</u> [subsection]; or[,]
(ii) not previously treated the injured	(ii) not previously treated the injured
employee, then the referral doctor shall bill the MMI	employee, then the referral doctor shall bill the MMI
evaluation in accordance with paragraph (3)(C) of	evaluation in accordance with paragraph (3)(C) of
this subsection.	this <u>section</u> [subsection].
(C) An examining doctor, other than the	(C) An examining doctor, other than the
treating doctor, shall bill using CPT Code 99456.	treating doctor, shall bill using CPT <u>code</u> [Code]
Reimbursement shall be \$350.	99456. Reimbursement shall be \$350.
(4) The following applies for billing and	(4) The following applies for billing and
reimbursement of an IR evaluation.	reimbursement of an IR evaluation.
(A) The HCP shall include billing components	(A) The <u>health care provider[HCP]</u> shall include
of the IR evaluation with the applicable MMI	billing components of the IR evaluation with the
evaluation CPT code. The number of body areas	applicable MMI evaluation CPT code. The number
rated shall be indicated in the units column of the	of body areas rated shall be indicated in the units
billing form.	column of the billing form.
(B) When multiple IRs are required as a	(B) When multiple IRs are required as a
component of a designated doctor examination	component of a designated doctor examination
under §130.6 of this title (relating to Designated	under [§130.6 of] this title[(relating to Designated
Doctor Examinations for Maximum Medical	Doctor Examinations for Maximum Medical
Improvement and/or Impairment Ratings), the	Improvement and/or Impairment Ratings)], the
designated doctor shall bill for the number of body	designated doctor shall bill for the number of body
areas rated and be reimbursed \$50 for each	areas rated and be reimbursed \$50 for each
additional IR calculation. Modifier "MI" shall be	additional IR calculation. Modifier "MI" shall be
added to the MMI evaluation CPT code.	added to the MMI evaluation CPT code.
(C) For musculoskeletal body areas, the	(C) For musculoskeletal body areas, the
examining doctor may bill for a maximum of three	examining doctor may bill for a maximum of three
body areas.	body areas.
	,
(i) Musculoskeletal body areas are defined	(i) Musculoskeletal body areas are defined as
as follows:	follows:
(I) spine and pelvis;	(I) spine and pelvis;
(.) op o on a porrio;	(.) opinio sina poinio;
(II) upper extremities and hands; and,	(II) upper extremities and hands; and[,]
(III) lower extremities (including feet).	(III) lower extremities (including feet).
(ii) The MAR for musculoskeletal body areas	(ii) The MAR for musculoskeletal body areas
shall be as follows.	shall be as follows.
(I) \$150 for each body area if the	(I) \$150 for each body area if the <u>diagnosis</u>

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:	(II) If full physical evaluation, with range of motion, is performed:
(-a-) \$300 for the first musculoskeletal body area; and	(-a-) \$300 for the first musculoskeletal body area; and
(-b-) \$150 for each additional musculoskeletal body area.	(-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 <u>health care provider[HCP</u>], other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the <u>health care provider[HCP</u>] shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the <u>health care provider[HCP</u>] 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.	(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) Non-musculoskeletal body areas are defined as follows:
(I) body systems;	(I) body systems;
(II) body structures (including skin); and,	(II) body structures (including skin); and $[,]$
(III) mental and behavioral disorders.	(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.	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:	(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.	(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.	(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:	(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.	(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.	(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 <u>Labor Code and</u> [Act and Division Rules,] Chapter 130 of this title. The treating doctor shall bill using CPT <u>code</u> [Code] 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed \$50.