

1 given effect without the invalid provision or application and the provisions of §§134.209,
2 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and
3 134.260~~[134.250]~~ of this title are severable.

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

6 (f) For coding, billing, reporting, and reimbursement of medical services, Texas
7 workers' compensation system participants must apply Medicare payment policies, as
8 defined in §134.203 of this chapter and in Chapter 133 of this title, that are in effect on
9 the date a service is provided with any additions or exceptions in the rules.

10

1 **§134.210. Medical Fee Guideline for Workers' Compensation Specific Services**

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

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

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

15 (2) Modifying circumstance ~~must~~~~shall~~ be identified by use of the
16 appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS
17 codes. Where HCPCS modifiers apply, insurance carriers ~~must~~~~shall~~ treat them in
18 accordance with Medicare and Texas Medicaid rules. ~~In addition~~~~Additionally~~, division-
19 specific modifiers are identified in subsection (f)~~(e)~~ of this section and in §§134.235,
20 134.240, 134.250, and 134.260. When two or more modifiers ~~apply~~~~are applicable~~ to a
21 single HCPCS code, indicate each modifier on the bill.

22 (3) A 10% ~~percent~~ incentive payment ~~must~~~~shall~~ be added to the
23 maximum allowable reimbursement (MAR) for services outlined in §§134.220, 134.225,
24 134.235, 134.240, 134.250, and 134.260~~134.250~~ of this title and subsection (d) of this
25 section that are performed in designated workers' compensation underserved areas in
26 accordance with §134.2 of this title. However, reimbursement for a missed appointment
27 under §134.240 does not qualify for the 10% incentive payment.

1 (4) Fees established in §§134.235, 134.240, 134.250, and 134.260 of this
2 title will be adjusted annually by applying the adjustment factor identified in
3 §134.203(c)(2). The adjusted fees will be effective on January 1 of each new calendar
4 year.

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

8 (d) When billing for services in §§134.215, 134.220, 134.225, or 134.230, and there
9 is no negotiated or contracted amount that complies with Labor Code §413.011,
10 reimbursement ~~must~~shall be the least of the:

11 (1) MAR amount;

12 (2) health care provider's usual and customary charge~~[-unless directed by~~
13 ~~division rule to bill a specific amount]~~; or

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

16 (e) For services provided under §§134.235, 134.240, 134.250, or 134.260, health
17 care providers must bill and be reimbursed the MAR.

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

21 (1) 25--This modifier must be added to CPT code 99456 when the division
22 ordered the designated doctor to perform an examination of an injured employee with
23 one or more of the diagnoses listed in §127.130(b)(9)(B)-(I) of this title.

24 (2) 52--This modifier must be added to CPT code 99456 when the division
25 ordered the designated doctor to perform an examination of an injured employee and
26 the injured employee missed the examination.

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

4 (4)~~[(2)]~~ CP, chronic pain management program--This modifier must~~[shall]~~
5 be added to CPT code 97799 to indicate chronic pain management program services
6 were performed.

7 (5)~~[(3)]~~ FC, functional capacity--This modifier must~~[shall]~~ be added to CPT
8 code 97750 when a functional capacity evaluation is performed.

9 (6)~~[(4)]~~ MR, outpatient medical rehabilitation program--This modifier shall
10 be added to CPT code 97799 to indicate outpatient medical rehabilitation program
11 services were performed.

12 (7)~~[(5)]~~ MI, multiple impairment ratings--This modifier must~~[shall]~~ be
13 added to CPT code 99456~~[99455]~~ when the designated doctor is required to complete
14 multiple impairment ratings calculations.

15 (8)~~[(6)]~~ NM, not at maximum medical improvement (MMI)--This modifier
16 must~~[shall]~~ be added to the appropriate MMI CPT code to indicate that the injured
17 employee has not reached MMI when the purpose of the examination was to determine
18 MMI.

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

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

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

1 (9)[(10)] VR, review report--This modifier must[~~shall~~] be added to CPT code
2 99455 to indicate that the service was the treating doctor's review of reports[~~report(s)~~]
3 only.

4 (10) V3,[~~(11) V1, level of MMI for~~] treating doctor evaluation of MMI--This
5 modifier must[~~shall~~] be added to CPT code 99455 when the office visit level of service is
6 equal to CPT code 99213[~~a "minimal" level~~].

7 (11) V4,[~~(12) V2, level of MMI for~~] treating doctor evaluation of MMI--This
8 modifier must[~~shall~~] be added to CPT code 99455 when the office visit level of service is
9 equal to CPT code 99214[~~"self limited or minor" level~~].

10 (12) V5,[~~(13) V3, level of MMI for~~] treating doctor evaluation of MMI--This
11 modifier must[~~shall~~] be added to CPT code 99455 when the office visit level of service is
12 equal to CPT code 99215[~~"low to moderate" level~~].

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

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

19 (13)[(16)] WC, work conditioning--This modifier must[~~shall~~] be added to
20 CPT codes[~~code~~] 97545 and 97546 to indicate work conditioning was performed.

21 (14)[(17)] WH, work hardening--This modifier must[~~shall~~] be added to CPT
22 codes[~~code~~] 97545 and 97546 to indicate work hardening was performed.

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

1 (15)~~(19)~~ W1, case management for treating doctor--This modifier
2 must~~[shall]~~ be added to the appropriate case management billing code activities when
3 performed by the treating doctor.

4 (16)~~(20)~~ W5, designated doctor examination for impairment or
5 attainment of MMI--This modifier must~~[shall]~~ be added to the appropriate examination
6 code performed by a designated doctor when determining impairment caused by the
7 compensable injury and in attainment of MMI.

8 (17)~~(21)~~ W6, designated doctor examination for extent--This modifier
9 must~~[shall]~~ be added to the appropriate examination code performed by a designated
10 doctor when determining extent of the injured employee's compensable injury.

11 (18)~~(22)~~ W7, designated doctor examination for disability--This modifier
12 must~~[shall]~~ be added to the appropriate examination code performed by a designated
13 doctor when determining whether the injured employee's disability is a direct result of
14 the work-related injury.

15 (19)~~(23)~~ W8, designated doctor examination for return to work--This
16 modifier must~~[shall]~~ be added to the appropriate examination code performed by a
17 designated doctor when determining the ability of the injured employee to return to
18 work.

19 (20)~~(24)~~ W9, designated doctor examination for other similar issues--This
20 modifier must~~[shall]~~ be added to the appropriate examination code performed by a
21 designated doctor when determining other similar issues.

22

1 **§134.235. Required Medical Examinations**~~[Return to Work/Evaluation of Medical~~
2 ~~Care]~~

3 (a) Required medical examination doctors (RME doctors) must perform
4 examinations in accordance with Labor Code §§408.004, 408.0041, 408.0043, and
5 408.0045; and division rules.

6 (b) Each examination and its individual billable components will be billed and
7 reimbursed separately.

8 (c) When conducting an insurance carrier-requested examination to determine
9 impairment or attainment of maximum medical improvement, the RME doctor must bill,
10 and the insurance carrier must reimburse, using CPT code 99456, with the modifiers and
11 at the rates specified in paragraphs (c)(2)-(3).

12 (1) The total maximum allowable reimbursement (MAR) for a maximum
13 medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI
14 evaluation reimbursement plus the reimbursement for the body area or areas evaluated
15 for the assignment of an IR. The MMI or IR examination must include:

16 (A) the examination;

17 (B) consultation with the injured employee;

18 (C) review of the records and films;

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

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

25 (2) RME doctors must only bill and be reimbursed for an MMI or IR
26 examination if they are an authorized doctor in accordance with the Labor Code, and
27 Chapter 130 and §180.23 of this title.

1 (A) If the RME doctor determines that MMI has not been reached,
2 the RME doctor must bill, and the insurance carrier must reimburse, the MMI evaluation
3 portion of the examination in accordance with subsections (c)(1) and (c)(3) of this
4 section. The RME doctor must add modifier "NM."

5 (B) If the RME doctor determines that MMI has been reached and
6 there is no permanent impairment because the injury was sufficiently minor, and an IR
7 evaluation was not warranted, the RME doctor must only bill, and the insurance carrier
8 must only reimburse, the MMI evaluation portion of the examination in accordance with
9 subsections (c)(1) and (c)(3) of this section.

10 (C) If the RME doctor determines MMI has been reached and an IR
11 evaluation is performed, the RME doctor must bill, and the insurance carrier must
12 reimburse, both the MMI evaluation and the IR evaluation portions of the examination
13 in accordance with this subsection.

14 (3) MMI. MMI examinations will be reimbursed at \$437.50.

15 (4) IR. For IR evaluations, the RME doctor must bill, and the insurance
16 carrier must reimburse, the components of the IR evaluation. Indicate the number of
17 body areas rated in the units column of the billing form.

18 (A) For musculoskeletal body areas, the RME doctor may bill for a
19 maximum of three body areas.

20 (i) Musculoskeletal body areas are:

21 (I) spine and pelvis;

22 (II) upper extremities and hands; and

23 (III) lower extremities (including feet).

24 (ii) For musculoskeletal body areas:

25 (I) the reimbursement for the first musculoskeletal
26 body area is \$360; and

1 (II) the reimbursement for each additional
2 musculoskeletal body area is \$180.

3 (B) For non-musculoskeletal body areas, the RME doctor may bill,
4 and the insurance carrier must reimburse, for each non-musculoskeletal body area
5 examined.

6 (i) Non-musculoskeletal body areas are:

7 (I) body systems;

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

9 (III) mental and behavioral disorders.

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

12 (iii) The reimbursement for the assignment of an IR in a non-
13 musculoskeletal body area is \$180.

14 (C) If the examination for the determination of MMI or the
15 assignment of IR requires testing that is not outlined in the AMA Guides, the RME
16 doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT
17 code or codes according to the applicable fee guideline in addition to the fees for the
18 examination by the RME doctor outlined in subsection (c) of this section.

19 (d) When conducting an insurance carrier-requested examination to determine
20 the extent of the employee's compensable injury, whether the injured employee's
21 disability is a direct result of the compensable injury, the ability of the injured employee
22 to return to work, other similar issues, or appropriateness of medical care, the RME
23 doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and at
24 the rates specified in paragraphs (d)(1)-(5).

25 (1) Extent of injury. The reimbursement rate for determining the extent of
26 the injured employee's compensable injury is \$660.

1 (2) Disability. The reimbursement rate for determining whether the injured
2 employee's disability is a direct result of the work-related injury is \$565.

3 (3) Return to work. The reimbursement rate for determining the ability of
4 the injured employee to return to work is \$565.

5 (4) Other similar issues. The reimbursement rate for determining other
6 similar issues is \$565.

7 (5) Appropriateness of health care. The reimbursement rate for
8 appropriateness of health care as defined in §126.6 (concerning Required Medical
9 Examination) and Labor Code §408.004 is \$565.

10 (e) When the RME doctor refers testing to a specialist, the referral specialist must
11 bill, and the insurance carrier must reimburse, the appropriate CPT code or codes for the
12 tests required for the assignment of IR, according to the applicable division fee
13 guideline. Documentation is required.

14 ~~[The following shall apply to return to work (RTW)/evaluation of medical care~~
15 ~~(EMC) examinations. When conducting a division or insurance carrier requested~~
16 ~~RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT~~
17 ~~code 99456 with modifier "RE." In either instance of whether maximum medical~~
18 ~~improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall~~
19 ~~be \$500 in accordance with §134.240 of this title and shall include division required~~
20 ~~reports. Testing that is required shall be billed using the appropriate CPT codes and~~
21 ~~reimbursed in addition to the examination fee.]~~

1 **§134.239. Billing for Work Status Reports**

2 Work status reports described by §129.5 of this title may not be billed or
3 reimbursed separately when completed as a component of an ordered
4 examination.~~[When billing for a work status report that is not conducted as a part of the~~
5 ~~examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title.]~~
6

1 **§134.240. Designated Doctor Examinations**

2 (a) Designated doctors must perform examinations in accordance with Labor
3 Code §§408.004, 408.0041, and 408.151 and division rules.

4 (b) The designated doctor must bill, and the insurance carrier must reimburse, for
5 a missed appointment when the injured employee does not attend a properly scheduled
6 or rescheduled examination under 28 TAC §127.5(h)-(j).

7 (1) The designated doctor may bill for the missed appointment fee when:

8 (A) the injured employee does not attend a scheduled appointment,

9 and

10 (B) the designated doctor waits at the examination location for at
11 least 30 minutes after the scheduled appointment time.

12 (2) When billing for the missed appointment, the designated doctor must
13 bill CPT code 99456 with modifier 52.

14 (3) Reimbursement for a missed appointment is \$150.

15 (4) Reimbursement for a missed appointment under this section does not
16 qualify for the 10% incentive payment under §134.2 of this chapter.

17 (c) Each examination and its individual billable components will be billed and
18 reimbursed separately.

19 (d) When conducting a designated doctor examination, the designated doctor
20 must bill, and the insurance carrier must reimburse, using CPT code 99456 and with the
21 modifiers and rates specified in subsections (d)(1)-(7).

22 (1) The total maximum allowable reimbursement (MAR) for a maximum
23 medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI
24 evaluation reimbursement plus the reimbursement for the body area or areas evaluated
25 for the assignment of an IR. The MMI or IR examination must include:

26 (A) the examination;

27 (B) consultation with the injured employee;

1 (C) review of the records and films;
2 (D) the preparation and submission of reports (including the
3 narrative report and responding to the need for further clarification, explanation, or
4 reconsideration), calculation tables, figures, and worksheets; and

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

8 (2) A designated doctor must only bill and be reimbursed for an MMI or IR
9 examination if they are an authorized doctor in accordance with the Labor Code, and
10 Chapter 130 and §180.23 of this title.

11 (A) If the designated doctor determines that MMI has not been
12 reached, the MMI evaluation portion of the examination must be billed and reimbursed
13 in accordance with subsection (d) of this section. The designated doctor must add
14 modifier "NM."

15 (B) If the designated doctor determines that MMI has been reached
16 and there is no permanent impairment because the injury was sufficiently minor, an IR
17 evaluation is not warranted and only the MMI evaluation portion of the examination
18 must be billed and reimbursed in accordance with subsection (d) of this section.

19 (C) If the designated doctor determines MMI has been reached and
20 an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions
21 of the examination must be billed and reimbursed in accordance with subsection (d) of
22 this section.

23 (3) MMI. MMI examinations will be reimbursed at \$437.50, and the
24 designated doctor must apply the additional modifier "W5."

25 (4) IR. For IR evaluations, the designated doctor must bill, and the
26 insurance carrier must reimburse, the components of the IR evaluation. The designated

1 doctor must apply the additional modifier "W5." Indicate the number of body areas
2 rated in the units column of the billing form.

3 (A) For musculoskeletal body areas, the designated doctor may bill
4 for a maximum of three body areas.

5 (i) Musculoskeletal body areas are:

6 (I) spine and pelvis;

7 (II) upper extremities and hands; and

8 (III) lower extremities (including feet).

9 (ii) For musculoskeletal body areas:

10 (I) the reimbursement for the first musculoskeletal
11 body area is \$360; and

12 (II) the reimbursement for each additional
13 musculoskeletal body area is \$180.

14 (B) For non-musculoskeletal body areas, the designated doctor
15 must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body
16 area examined.

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

18 (I) body systems;

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

20 (III) mental and behavioral disorders.

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

23 (iii) The reimbursement for the assignment of an IR in a non-
24 musculoskeletal body area is \$180.

25 (iv) The test or tests required by Chapter 127 of this title for
26 the assignment of IR, as outlined in the AMA Guides, must be billed using the

1 appropriate CPT code or codes and reimbursed under the applicable division fee
2 guideline in addition to the fees outlined in subsection (b) and (d)(1)-(3) of this section.

3 (C) If the examination for the determination of MMI or the
4 assignment of IR requires testing authorized by Chapter 127 of this title that is not
5 outlined in the AMA Guides, the appropriate CPT code or codes must be billed, and the
6 insurance carrier must reimburse, according to the applicable division fee guideline, in
7 addition to the fees outlined in subsections (b) and (d)(1)-(3) of this section;

8 (D) When multiple IRs are required as a component of a designated
9 doctor examination under this title, the designated doctor must bill for the number of
10 body areas rated, and the insurance carrier must reimburse, \$60 for each additional IR
11 calculation.

12 (E) When the division requires the designated doctor to complete
13 multiple IR calculations, the designated doctor must apply the additional modifier "MI."

14 (5) Extent of injury. The reimbursement rate for determining the extent of
15 the employee's compensable injury is \$660, and the designated doctor must apply the
16 additional modifier "W6."

17 (6) Disability. The reimbursement rate for determining whether the injured
18 employee's disability is a direct result of the work-related injury is \$565, and the
19 designated doctor must apply the additional modifier "W7."

20 (7) Return to work. The reimbursement rate for determining the ability of
21 the injured employee to return to work is \$565, and the designated doctor must apply
22 the additional modifier "W8."

23 (8) Other similar issues. The reimbursement rate for determining other
24 similar issues is \$565, and the designated doctor must apply the additional
25 modifier "W9" when examining issues similar to those described in subsection (d)(1)-(6).

26 (e) Required testing or evaluation under §127.10 of this title must be billed using
27 the appropriate CPT codes. Reimbursement will be according to §134.203 or other

1 applicable division fee guideline in addition to the examination fee. If a designated
2 doctor refers an injured employee for additional testing or evaluation under §127.10 of
3 this title:

4 (1) The 95-day period for timely submission of the bill begins on the date
5 of service of the additional testing or evaluation.

6 (2) The dates of service (CMS-1500/field 24A) are as follows: the "From"
7 date is the date of the designated doctor examination, and the "To" date is the date of
8 service of the additional testing or evaluation.

9 (3) The designated doctor and any referral providers must include the
10 DWC-provided assignment number in the prior authorization field (CMS-1500/field 23)
11 in accordance with §133.10(f)(1)(N).

12 (f) When the designated doctor refers an injured employee to a specialist for
13 additional testing or evaluation under §127.10 of this title, the referral specialist must
14 bill:

15 (1) using the appropriate CPT codes, and the insurance carrier must
16 reimburse, according to §134.203 or other applicable division fee guideline in addition
17 to the examination fee;

18 (2) using the assignment number provided by the designated doctor; and

19 (3) attaching the required documentation.

20 (g) When the division orders the designated doctor to perform an examination of
21 an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B)-(I) of
22 this title:

23 (1) The designated doctor must add modifier "25" to the appropriate
24 examination code when:

25 (A) determining IR or attainment of MMI;

26 (B) determining the extent of the employee's compensable injury;

1 (C) determining whether the injured employee's disability is a direct
2 result of the compensable injury;

3 (D) determining the ability of the injured employee to return to
4 work; or

5 (E) determining other similar issues.

6 (2) The designated doctor must add modifier "25" only one time for each
7 examination conducted, regardless of the number of diagnoses or the number of issues
8 the division ordered the designated doctor to examine.

9 (3) The designated doctor must bill, and the insurance carrier must
10 reimburse, \$300 in addition to the examination fee.

11 ~~[The following shall apply to designated doctor examinations.~~

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

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

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

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

1 ~~_____ (D) Whether the injured employee's disability is a direct result of the~~
2 ~~work-related injury shall be billed and reimbursed in accordance with §134.235 of this~~
3 ~~title, with the use of the additional modifier "W7";~~
4 ~~_____ (E) Ability of the employee to return to work shall be billed and~~
5 ~~reimbursed in accordance with §134.235 of this title, with the use of the additional~~
6 ~~modifier "W8"; and~~
7 ~~_____ (F) Issues similar to those described in subparagraphs (A) – (E) of~~
8 ~~this paragraph shall be billed and reimbursed in accordance with §134.235 of this title,~~
9 ~~with the use of the additional modifier "W9."~~
10 ~~_____ (2) When multiple examinations under the same specific division order are~~
11 ~~performed concurrently under paragraph (1)(C) – (F) of this section:~~
12 ~~_____ (A) the first examination shall be reimbursed at 100 percent of the~~
13 ~~set fee outlined in §134.235 of this title;~~
14 ~~_____ (B) the second examination shall be reimbursed at 50 percent of the~~
15 ~~set fee outlined in §134.235 of this title; and~~
16 ~~_____ (C) subsequent examinations shall be reimbursed at 25 percent of~~
17 ~~the set fee outlined in §134.235 of this title.]~~
18

1 **§134.250. Maximum Medical Improvement Evaluations and Impairment Rating**
2 **Examinations by Treating Doctors**

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

5 (a)~~[(1)]~~ The total maximum allowable reimbursement (MAR) for a maximum
6 medical improvement (MMI) or impairment rating (IR)~~[an MMI/IR]~~ examination is~~[shall~~
7 ~~be]~~ equal to the MMI evaluation reimbursement plus the reimbursement for the body
8 area or areas~~[area(s)]~~ evaluated for the assignment of an IR. The MMI or IR~~[MMI/IR]~~
9 examination must~~[shall]~~ include:

10 (1)~~[(A)]~~ the examination;

11 (2)~~[(B)]~~ consultation with the injured employee;

12 (3)~~[(C)]~~ review of the records and films;

13 (4)~~[(D)]~~ the preparation and submission of reports (including the
14 narrative report, and responding to the need for further clarification, explanation, or
15 reconsideration), calculation tables, figures, and worksheets; and

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

19 (b) Treating doctors must~~[(2) A health care provider shall]~~ only bill and be
20 reimbursed for an MMI or IR~~[MMI/IR]~~ examination if they are~~[the doctor performing the~~
21 ~~evaluation (i.e., the examining doctor) is]~~ an authorized doctor in accordance with the
22 Labor Code, and Chapter 130 and §180.23 of this title.

23 (1) If the treating doctor determines that MMI has not been reached, the
24 treating doctor must bill, and the insurance carrier must reimburse, the MMI evaluation
25 portion of the examination in accordance with subsections (c)(1) and (c)(2) of this
26 section.

1 (2) If the treating doctor determines MMI has been reached and there is
2 no permanent impairment because the injury was sufficiently minor, an IR evaluation is
3 not warranted and the treating doctor must bill, and the insurance carrier must
4 reimburse, only the MMI evaluation portion of the examination in accordance with
5 subsections (c)(1) and (c)(2) of this section.

6 (3) If the treating doctor determines MMI has been reached and an IR
7 evaluation is performed, the treating doctor must bill, and the insurance carrier must
8 reimburse, both the MMI evaluation and the IR evaluation portions of the examination
9 in accordance with subsection (c) of this section.

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

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

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

22 ~~_____ (3) The following applies for billing and reimbursement of an MMI~~
23 ~~evaluation.~~

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

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

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

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

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

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

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

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

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

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

22 (c) The following applies for billing and reimbursement of an MMI or IR
23 evaluation by a treating doctor.

24 (1) CPT code. The treating doctor must bill using CPT code 99455 with the
25 appropriate modifier. Modifiers "V3," "V4," or "V5" must be added to CPT code 99455 to
26 correspond with the last digit of the applicable office visit.

1 (2) MMI. MMI examinations must be reimbursed based on the applicable
2 established patient office visit level associated with the examination.

3 (3) IR. For IR evaluations, the treating doctor must bill, and the insurance
4 carrier must reimburse, the components of the IR evaluation. Indicate the number of
5 body areas rated in the units column of the billing form.

6 (A)~~(C)~~ For musculoskeletal body areas, the treating~~[examining]~~
7 doctor may bill for a maximum of three body areas.

8 (i) Musculoskeletal body areas are ~~[defined as follows]:~~

9 (I) spine and pelvis;

10 (II) upper extremities and hands; and

11 (III) lower extremities (including feet).

12 (ii) For musculoskeletal body areas:

13 (I) the reimbursement for the first musculoskeletal
14 body area is \$360; and

15 (II) the reimbursement for each additional
16 musculoskeletal body area is \$180.

17 ~~[The MAR for musculoskeletal body areas shall be as follows:~~

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

20 ~~_____ (II) If full physical evaluation, with range of motion, is~~
21 ~~performed:~~

22 ~~_____ (-a-) \$300 for the first musculoskeletal body~~
23 ~~area; and~~

24 ~~_____ (-b-) \$150 for each additional musculoskeletal~~
25 ~~body area.~~

26 ~~_____ (iii) If the examining doctor performs the MMI examination~~
27 ~~and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill~~

1 using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100
2 percent of the total MAR.

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

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

13 (B) For non-musculoskeletal body areas, the treating doctor must
14 bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area
15 examined.~~[(D) Non-musculoskeletal body areas shall be billed and reimbursed using the
16 appropriate CPT code(s) for the test(s) required for the assignment of IR.]~~

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

18 (I) body systems;

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

20 (III) mental and behavioral disorders.

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

23 (iii) The reimbursement for the assignment of an IR in a non-
24 musculoskeletal body area is \$180.

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

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

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

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

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

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

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

19 ~~_____ (v) The MAR for the assignment of an IR in a non-~~
20 ~~musculoskeletal body area shall be \$150.]~~

21 (d)[—(5)] If the examination for the determination of MMI or[and/or] the
22 assignment of IR requires testing that is not outlined in the AMA Guides, the treating
23 doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT
24 code or codes according to the applicable fee guideline[code(s) shall be billed and
25 reimbursed] in addition to the fees for the examination by the treating doctor outlined
26 in subsection (c)[paragraphs (3) and (4)] of this section.

1 (e)[~~—(6)~~] The treating doctor is required to review the certification of MMI and
2 assignment of IR performed by another doctor, as stated in the Labor Code and Chapter
3 130 of this title. The treating doctor must[~~shall~~] bill using CPT code 99455 with modifier
4 "VR" to indicate a review of the report only, and the insurance carrier must reimburse,
5 \$60[~~shall be reimbursed \$50~~].

6

1 **§134.260. Maximum Medical Improvement Evaluations and Impairment Rating**

2 **Examinations by Referral Doctors**

3 (a) The total maximum allowable reimbursement (MAR) for a maximum medical
4 improvement (MMI) or impairment rating (IR) examination is equal to the MMI
5 evaluation reimbursement plus the reimbursement for the body area or areas evaluated
6 for the assignment of an IR. The MMI or IR examination must include:

7 (1) the examination;

8 (2) consultation with the injured employee;

9 (3) review of the records and films;

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

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

16 (b) Referral doctors must only bill and be reimbursed for an MMI or IR
17 examination if they are an authorized doctor in accordance with the Labor Code, and
18 Chapter 130 and §180.23 of this title.

19 (1) If the referral doctor determines that MMI has not been reached, the
20 referral doctor must bill, and the insurance carrier must reimburse, the MMI evaluation
21 portion of the examination in accordance with subsections (c)(1) and (c)(2) of this
22 section. The referral doctor must add modifier "NM."

23 (2) If the referral doctor determines that MMI has been reached and there
24 is no permanent impairment because the injury was sufficiently minor and IR evaluation
25 is not warranted, the referral doctor must bill, and the insurance carrier must reimburse,
26 only the MMI evaluation portion of the examination in accordance with subsections
27 (c)(1) and (c)(2) of this section.

1 (3) If the referral doctor determines MMI has been reached and an IR
2 evaluation is performed, the referral doctor must bill, and the insurance carrier must
3 reimburse, both the MMI evaluation and the IR evaluation portions of the examination
4 in accordance with subsection (c) of this section.

5 (c) The following applies for billing and reimbursement of an MMI or IR
6 evaluation by a referral doctor.

7 (1) CPT code. The referral doctor must bill using CPT code 99456 with the
8 appropriate modifier.

9 (2) MMI. MMI examinations will be reimbursed at \$437.50.

10 (3) IR. For IR evaluations, the referral doctor must bill, and the insurance
11 carrier must reimburse, the components of the IR evaluation. Indicate the number of
12 body areas rated in the units column of the billing form.

13 (A) For musculoskeletal body areas, the referral doctor may bill for a
14 maximum of three body areas.

15 (i) Musculoskeletal body areas are:

16 (I) spine and pelvis;

17 (II) upper extremities and hands; and

18 (III) lower extremities (including feet).

19 (ii) For musculoskeletal body areas:

20 (I) the reimbursement for the first musculoskeletal
21 body area is \$360; and

22 (II) the reimbursement for each additional
23 musculoskeletal body area is \$180.

24 (B) For non-musculoskeletal body areas, the referral doctor must
25 bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area
26 examined.

27 (i) Non-musculoskeletal body areas are:

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- (I) body systems;
- (II) body structures (including skin); and
- (III) mental and behavioral disorders.

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

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is \$180.

(d) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the referral doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the examination by the referral doctor outlined in subsection (c) of this section.