CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER C. MEDICAL FEE GUIDELINES

[~~28 TAC §§134.235, 134.239, AND 134.240~~]

28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, AND 134.260

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) proposes: to repeal 28 TAC §§134.235, 134.239, and 134.240; amend 28 TAC §§134.209, 134.210, and 134.250; and adopt new 28 TAC §§134.235, 134.239, 134.240, and 134.260, concerning medical fee guidelines for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and maximum medical improvement (MMI) evaluations and impairment rating (IR) examinations by treating and referred doctors. The repeals, amendments, and new sections (collectively, "changes") implement Texas Labor Code Chapters 408 and 413, which govern workers' compensation benefits, including medical examinations required to establish benefit entitlements, and medical review to ensure compliance with DWC rules for health care, including medical policies and fee guidelines. The DWC medical advisor recommends the changes to the commissioner of workers' compensation under Labor Code §413.0511(b).

EXPLANATION. The changes adjust the billing methodology and reimbursement rates for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and MMI evaluations and IR examinations by treating and referred doctors. They adjust the fees once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024, and then after the initial adjustment, adjust the fees annually on January 1 by applying the MEI percentage adjustment factor in §134.203(c)(2) which is how most

other fees are adjusted annually in the system. They round the fees to whole dollars to simplify calculations and reduce errors. They eliminate unnecessary billing modifiers, eliminate a required sequence for modifiers, and replace the diagnosis-related estimate and range of motion billing methods with a single method of billing. They also create a $100 missed appointment fee and a $300 specialist fee. In addition, they eliminate tiering. For designated doctors and required medical examination doctors, all issues addressed within one examination will be paid at the established fee and not reduced.

The changes include restructuring and reorganization to move the requirements for each type of examination into a section that is specific to that type of examination, which will help to reduce the need for system participants to look in multiple different rules to find out what their obligations are. To that end, the changes repeal and replace: §134.235 to address billing and reimbursement for required medical examinations, §134.239 to clarify that the requirements for billing for work status reports align across the ordered examinations, and §134.240 to address billing and reimbursement for designated doctor examinations. The changes amend and restructure §134.250, concerning MMI and IR examinations by treating doctors, to conform with the other sections; and add new §134.260, concerning MMI and IR examinations by referred doctors, to clarify the specific provisions that apply to examinations that are conducted by authorized doctors as a result of a referral from a treating doctor under §130.1 of this title, concerning certification of MMI and evaluation of permanent impairment.

The changes are necessary to attract and retain doctors that perform certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and MMI evaluations and IR examinations by treating and referred doctors, by addressing billing and reimbursement issues, reducing disputes, and by decreasing the administrative burden of participating in the program. Labor Code Chapter 408 entitles an employee that sustains a compensable

injury to all health care reasonably required by the nature of the injury as and when needed. Specifically, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. To help determine the health care that meets those standards, the treating doctor manages and coordinates the injured employee's health care for the compensable injury, including referring the employee to a doctor authorized to determine MMI and to assign IRs when needed. The designated doctor program established under Chapter 408 provides for commissioner-ordered medical examinations to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, or other similar issues. Maintaining a viable program that ensures that injured employees can access examinations in a timely way is essential to meeting the statutory mandate of providing health care for injured employees.

Having too few doctors in the program has a negative impact on the doctors that remain in the system, injured employees, and insurance carriers. When there are too few doctors able to conduct the examinations needed to determine benefit levels, injured employees must often wait longer and travel further to attend an examination, which can delay dispute resolution and other essential processes. DWC last adjusted reimbursement rates for workers' compensation-specific services in January 2008 (33 TexReg 364). Over the past 14 years, DWC has experienced a decline in the numbers of doctors providing workers' compensation-specific services. This decline has been particularly pronounced among designated doctors certified under Labor Code §408.1225 and providing designated doctor examinations as Labor Code §408.0041 requires, and especially among licensed medical doctors and doctors of osteopathy. In December 2022, for the entire

state of Texas, there were only 63 available medical doctors, 10 doctors of osteopathic medicine, 177 doctors of chiropractic, and no doctors of podiatry, dental science, or optometry. Yet in that month, there were 1,259 designated doctor appointments for those 250 designated doctors to cover.

DWC held stakeholder meetings in March, September, and December 2022 to discuss issues with declining participation in the designated doctor program, including issues with billing logistics and reimbursement rates. DWC invited public comments on three separate informal drafts posted on DWC's website in August 2022, November 2022, and June 2023. In addition, DWC conducted a stakeholder survey to gather information about anticipated implementation costs and benefits in September 2023. DWC considered the comments it received at the meetings and on the informal drafts when drafting this proposal.

In April 2023, after gathering data about the program and soliciting input from system participants about how to maintain and increase participation in the designated doctor program and allow better access to specialized examinations, DWC adopted amendments to Chapter 127 of this title, concerning designated doctor procedures and requirements, and §180.23 of this title, concerning division-required training for doctors. Those rules addressed certification, training, and procedures for designated doctors and were required to address administrative and logistical inefficiencies, and to improve access to examinations, to make participation in the program possible and attractive for more doctors. They were one part of the project to ensure the designated doctor program's viability, in compliance with the Labor Code. After their adoption, DWC saw a near-immediate increase in the numbers of doctors applying to the program, which was very encouraging.

However, the common theme throughout the input-gathering process about how to improve the program was billing and reimbursement for certain workers'

compensation-specific services, especially designated doctor examinations. Nearly every comment DWC received mentioned some combination of issues about the fees for designated doctor examinations--that they were insufficient, had not been adjusted for inflation or other economic factors in over a decade, did not take into account missed appointments or the time spent reviewing injured employees' medical records, and other similar issues. In adopting the amendments to Chapter 127 and §180.23, DWC stated that billing and reimbursement issues would be addressed in a separate rule project. As a result, the changes in this rule proposal are another part of the project, and are necessary to account for past and future inflation, examination complexity, and other economic factors that affect participation in the designated doctor program.

Labor Code Chapter 408 governs workers' compensation benefits. It entitles an injured employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. It requires a variety of workers' compensation-specific services, including required medical examinations; designated doctor examinations; MMI evaluations and IR examinations; and return-to-work and evaluation of medical care examinations.

Labor Code Chapter 413, Subchapter B, Medical Services and Fees, requires in part that the commissioner of workers' compensation adopt health care reimbursement policies and guidelines, develop one or more conversion factors or other payment adjustment factors, and provide for reasonable fees for the evaluation and management of care. Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Medical policies and guidelines must be designed to ensure the quality of medical care and to achieve effective medical cost control; designed to enhance a timely and appropriate return to work; and consistent with §§413.013, 413.020, 413.052, and 413.053.

The changes are necessary to comply with the mandates for administering the workers' compensation benefit and fee system in Labor Code Chapters 408 and 413. The proposal also includes nonsubstantive editorial and formatting changes throughout that make updates for plain language and agency style to improve the rule's clarity.

Section 134.209. The amendments to §134.209 add references to new §134.260 and clarify that the new and amended sections apply to workers' compensation-specific codes, services, and programs provided on or after June 1, 2024. Amending §134.209 is necessary to conform §134.209 to the new and amended sections and ensure that the rules are accurate.

Section 134.210. The amendments to §134.210 clarify that reimbursement for a missed appointment under §134.240 does not qualify for the 10% incentive payment for services performed in designated workers' compensation underserved areas. The amendments provide that fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be:

- adjusted once by applying the MEI percentage adjustment factor for the period 2009 - 2024;

- adjusted annually by applying the MEI percentage adjustment factor in §134.203(c)(2);

- rounded to whole dollars; and

- effective on January 1 of each new calendar year.

The amendments clarify that, for services provided under §§134.235, 134.240, 134.250, or 134.260, health care providers must bill and be reimbursed the maximum allowable reimbursement (MAR).

In addition, the amendments simplify the modifiers that health care providers must use when billing professional medical services for correct coding, reporting, billing, and reimbursement based on procedure codes. The amendments add modifier 25 and specify that it must be added to Current Procedural Terminology (CPT) code 99456 for designated doctor examinations involving one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title, including traumatic brain injuries, spinal cord injuries and diagnoses, severe burns, complex regional pain syndrome, joint dislocation, one or more fractures with vascular injury, one or more pelvis fractures, multiple rib fractures, complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics, chemical exposure, and heart or cardiovascular conditions. The amendments add modifier 52 and specify that it must be added to CPT code 99456 when DWC ordered the designated doctor to perform an examination of an injured employee, and the injured employee failed to attend the examination. The amendments correct an error that listed the incorrect CPT code for multiple IRs. The amendments delete the RE, SP, TC, and WP modifiers. The amendments realign the "V" modifiers that must be added to CPT code 99455 by deleting V1 and V2 and replacing the more subjective descriptors ("minimal," "self-limited," "minor," "low to moderate," and "moderate to high severity") with references to CPT code standards. For example, per the amendments, modifier V3, treating doctor evaluation of MMI, must now be added to CPT code 99455 when the office visit level of service is equal to CPT code 99213. The amendments also include CPT code 97546 for modifiers WC (work conditioning) and WH (work hardening).

Amending §134.210 is necessary to decrease administrative burdens by eliminating unnecessary billing modifiers and eliminating a required sequence for modifiers, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system. As fees were last

adjusted in 2008, an increase to account for the intervening years of inflation is indicated, and the amendment to §134.210 that adjusts fees annually to account for future inflation is necessary to align with the annual updates in §134.203 of this chapter, concerning the medical fee guideline for professional services.

Section 134.235. New §134.235 renames the section "Required Medical Examinations" to capture the types of examinations more accurately than just the previous title of "Return to Work/Evaluation of Medical Care." It contains statutory references, requires that each examination and its individual billable components be reimbursed separately, and describes the billing methods and reimbursement amounts for a required medical examination (RME) doctor examining an injured employee for MMI or IR. Those billing methods and requirements were previously in §134.250 of this title, but have been moved to new §134.235 to allow RME doctors to find their billing requirements in one section. In addition, new §134.235 describes what the MMI or IR examination must include, specifies increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the American Medical Association (AMA) guides, requires billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the MMI and IR examinations. New §134.235 sets increased rates for examinations to determine extent of injury, disability, return to work, other similar issues, and appropriateness of health care. In addition, for required medical examination doctors, all issues addressed within one examination will be paid at the established fee and not reduced. Finally, new §134.235 sets billing and reimbursement requirements for when the RME doctor refers testing to a specialist. It also requires documentation of the referral.

Repealing §134.235 and adopting new §134.235 is necessary to consolidate RME doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

Section 134.239. New §134.239 states that work status reports may not be billed or reimbursed separately when they are completed as a component of an ordered examination. Repealing §134.239 and adopting new §134.239 is necessary to update references to conform with the restructured sections and clarify the language. The change does not affect how work status reports are billed in practice.

Section 134.240. New §134.240 specifies billing and reimbursement requirements for designated doctor examinations. It contains statutory references, provides for a $100 missed appointment fee, requires that each examination and its individual billable components be reimbursed separately, and describes the billing methods and reimbursement amounts for a designated doctor examination. In addition, new §134.240 sets the total MAR for an MMI or IR examination, describes what the MMI or IR examination must include and how it must be billed and reimbursed, specifies increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, requires billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the MMI and IR examinations. New §134.240 sets increased rates for examinations to determine extent of injury, disability, return to work, and other similar issues. New §134.240 also sets billing

and reimbursement requirements for when the designated doctor refers testing to a specialist, and it requires documentation of the referral. It also specifies that the 95-day period for timely submission of the designated doctor bill for the examination begins on the date of service of the additional testing or evaluation, and that the designated doctor and any referral health care providers must include the DWC-provided assignment number in the prior authorization field, per §133.10(f)(1)(N) of this title. In addition, for designated doctors, all issues addressed within one examination will be paid at the established fee and not reduced. Finally, new §134.240 sets a $300 specialist fee in addition to the examination fee for certain specialized diagnoses.

Based on feedback from many designated doctors in the system, DWC included the missed appointment fee to compensate, at least in part, designated doctors that schedule an examination appointment with an injured employee, do the required medical record review, prepare for the examination, travel to the appointment, and then have the injured employee not attend the appointment. In the current system, those designated doctors would not be compensated for that missed appointment or the work they performed to prepare for it. The missed appointment fee acknowledges the work the designated doctors are required to do to prepare for an examination.

The specialist fee also acknowledges designated doctors' time and effort spent in gaining specialty certifications and expertise. It reimburses board-certified physicians that participate in the designated doctor program and examine injured employees with certain complex injuries or diagnoses. DWC expects that the specialist fee will help increase the numbers of board-certified physicians in the program, which will reduce delays in examinations for employees with complex injuries or diagnoses and contribute to overall system health and efficiency.

Repealing §134.240 and adopting new §134.240 is necessary to consolidate designated doctors' billing and reimbursement requirements into one section to increase

efficiency and ease of use and decrease the possibility of errors. It is also necessary to put in place a missed appointment fee to compensate designated doctors for the time and expense they incur in reviewing medical records and traveling to the exam location when the injured employee does not attend the examination; and to set a specialist fee for examinations that require particular board certifications and expertise. In addition, repealing §134.240 and adopting new §134.240 is necessary to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines. It is also necessary to attract and retain doctors in the system.

Section 134.250. The amendments to §134.250 rename the section "Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Treating Doctors" to reflect the restructuring in this rule. The amendments move the requirements for required medical examinations into new §134.235, for designated doctors into new §134.240, and for referred doctors into new §134.260. The amendments make §134.250 specific to treating doctors, so treating doctors will be able to find their billing requirements in one section. They specify the billing methods and reimbursement requirements for MMI and IR examinations, and they permit a treating doctor that is not authorized to assign an IR to refer the injured employee to an authorized doctor for the examination and certification of MMI and IR, specifying that the referred doctor must bill under §134.260. In addition, the amendments to §134.250 specify increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, require billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for examination by the treating doctor. Finally, the amendments increase the reimbursement rate for a treating

doctor reviewing the certification of MMI and assignment of IR performed by another doctor (referred doctor). Amending §134.250 is necessary to consolidate treating doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

Section 134.260. New §134.260 concerns MMI evaluations and IR examinations by referred doctors. It describes what the MMI or IR examination must include, specifies increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, requires billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the MMI and IR examinations. Adopting new §134.260 is necessary to consolidate referred doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Deputy Commissioner of Health and Safety Mary Landrum has determined that during each year of the first five years the proposed amendments are in effect, there will be minimal fiscal impact on state and local governments as a result of enforcing or administering the sections, other than that imposed by the statute. This determination was made because

the proposed amendments do not add to or decrease state revenues or expenditures, and because local and state government entities are only involved in enforcing or complying with the proposed amendments when acting in the capacity of a workers' compensation insurance carrier. Those entities will be impacted in the same way as an insurance carrier and will realize the same benefits from the updates in the rules. They include the State Office of Risk Management, the Texas Department of Transportation, the University of Texas System Administration, and the Texas A&M University System Administration.

Deputy Commissioner Landrum does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the changes are in effect, Deputy Commissioner Landrum expects that enforcing and administering them will have the public benefits of reducing administrative burdens by eliminating unnecessary billing modifiers, eliminating a required sequence for modifiers, replacing the diagnosis-related estimate and range of motion billing methods with a single method of billing, and restructuring and editing the rules to make them more user-friendly and easier to comply with, which promotes transparent and efficient regulation.

Deputy Commissioner Landrum also expects that enforcing and administering the rules will have the public benefits of maintaining and bolstering a workers' compensation benefit system that has enough participating doctors and does not produce unnecessary delays in health care or in resolving medical disputes, compensating participating doctors fairly and in accordance with the Labor Code's statutory mandates for fee guidelines, and ensuring that the rules conform to Labor Code Chapters 408 and 413.

Labor Code §413.011 requires that the commissioner adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement

structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. Labor Code §413.012 requires DWC to review medical policies and fee guidelines at least every two years to reflect fair and reasonable fees and medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision is conducted. DWC reviewed billing methodologies and reimbursement amounts to ensure that these medical policies and fee guidelines align with the need to attract and retain an adequate number of qualified designated doctors, RME doctors, and MMI and IR certified doctors participating in the workers' compensation system. DWC analyzed designated doctor and RME order data, and billing information for the certification of MMI and IR by treating and referred doctors, to determine the cost of the proposed amendments to the workers' compensation system.

Injured employees will benefit from the rules because the fee increases and annual MEI adjustments will encourage additional doctors to participate in the workers' compensation system as designated doctors, RME doctors, and MMI and IR certified doctors, which will increase injured employees' access to these services.

Insurance carriers, certified self-insurers, and employers will benefit from having a larger and more stable pool of participating doctors to support access to high-quality health care and return-to-work initiatives. They will also benefit from the predictability and consistency of the annual MEI adjustments, reduced administrative burdens, reduced medical fee dispute actions, and general system health.

Health care providers will benefit from the reimbursement modifications in the rules. The increase in reimbursement reflects the increased costs for providing workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and MMI evaluations and IR examinations by treating and referred doctors, as well as from annual inflation and economic changes.

Health care providers performing these services will benefit from the annual MEI adjustments that ensure that economic changes will be reflected annually. Designated doctors will also benefit from the simplified billing requirements, increased certainty of payment from the clarification of when the 95-day billing period begins, and decreased need for medical fee disputes about the payment of designated doctor bills and bills from testing and referral health care providers associated with the designated doctor examination.

Deputy Commissioner Landrum expects that, for each year of the first five years, the changes will impose an economic cost on persons required to comply with them. Based on DWC's statutory responsibilities to maintain programs to provide workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and MMI evaluations and IR examinations by treating and referred doctors, and to periodically review and update medical policies and fee guidelines, and based on the feedback that DWC collected from stakeholders, DWC estimates the following costs from the changes.

For the affected programs, DWC estimates that based on calendar year (CY) 2022 activity, the total system impact from the changes will be about $9 million over CY 2022 reimbursement. That includes a one-time initial adjustment in rates based on the accrued changes in the MEI since the rates were last adopted, plus costs associated with removing tiering, adding the missed appointment fee, and adding the specialist fee. For the past five years, the annual change in the MEI has ranged from 1.4% to 4.6%, averaging 2.8%. Based on this estimated average future year over previous year percentage, DWC estimates the increase in reimbursement to be a little more than $1 million per year. To help offset costs for teaching and training staff on the changes, DWC expects to provide free training presentations with specific billing examples after the rule is adopted but before it becomes effective.

Insurance carriers and certified self-insurers will incur costs from the MEI initial adjustment for inflation for the period 2009 - 2024, from the annual MEI adjustment, from removing tiering and adding the missed appointment and specialist fees, and from any modifications to their bill processing systems necessary to implement the changes. DWC expects that any needed system updates to accommodate the changed amounts will incur low, if any, costs because insurance carriers must already adjust for annual changes in Medicare billing, and the changes in the rules use the same annual MEI. Having a consistent, predictable annual adjustment makes programming and maintaining billing systems simpler and more efficient. DWC also anticipates that the benefits from reduced administrative burdens, such as billing clarity in being able to identify claims with associated designated doctor examinations easily, reduced medical fee dispute actions, a larger and more consistent pool of participating doctors, and improved general system health, will help offset the cost burden.

Health care providers will incur costs to modify their systems and train employees on the billing changes. Based on stakeholder feedback about implementation costs, DWC estimates that health care providers will need about a week and a half to update software and train staff, resulting in a one-time cost of about $400, but DWC expects that the anticipated savings of about $2,000 per year far outweighs the implementation cost. Stakeholders stated that the anticipated savings include reduced billing time and efforts following up on reimbursement, the MEI increase and ability to file claims electronically, getting paid for missed appointments, avoiding denial of payment for timely filing when referral testing is delayed, reduced medical fee dispute resolution expenses, and reduced administrative and supply costs. They also noted that the increased reimbursements bring the Texas program more in line with the current economic climate and other states, and expect that the changes will help retain and attract more health care providers.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. DWC has determined that the changes may have an adverse economic effect or a disproportionate economic impact on small or micro businesses, or on rural communities. The cost analysis in the Public Benefit and Cost Note section of this proposal also applies to these small and micro businesses and rural communities. Most of the potential cost from these rules impacts insurance carriers. DWC identified 145 insurance carriers that had more than $0 but less than $6 million total direct written premium nationally for workers' compensation insurance. These insurance carriers writing workers' compensation insurance in Texas meet the definition of a small business under Government Code §2006.001(2)(C). As a result, DWC estimates that the changes may affect 145 small or micro businesses.

In addition, most rural political subdivisions self-insure their workers' compensation responsibilities individually or as part of a pool, so their impacts and benefits will be similar to the insurance carriers'. The data readily available from the Texas Demographic Center and the United States Census Bureau divides the Texas population into "places" and counties. For census purposes, "place" includes census designated places, consolidated cities, and incorporated places. There are often multiple places in a county, and some places span multiple counties, so the reports DWC collects from political subdivisions that self-insure their workers' compensation liabilities may include places that span different counties. As a result, to get the best estimate of affected rural communities, DWC looked at the Texas Demographic Center's January 2023 estimated county populations. Government Code Chapter 487 defines "rural county" at various population levels, ranging from a maximum population of 125,000 to 150,000. But Government Code Chapter 490G defines "rural county" in part as a county with a population of less than 60,000. Insurance Code Chapter 845 defines "rural area" as a county with a population of 50,000 or less. Using the most inclusive definition, of the 254

Texas counties, 222 have a population of less than 150,000, and all of those contain one or more self-insuring political subdivisions. As a result, DWC estimates that the changes may affect 222 rural counties on some level.

The primary objectives of this proposal are to attract and retain doctors to participate in the designated doctor program and the MMI and IR certification program, as well as doctors providing required medical examinations, by revising and simplifying billing requirements, increasing fees for the various examination types and adjusting for previous and future inflation, and adding monetary incentives for participation of board-certified physicians in the designated doctor program. DWC considered the following alternatives to minimize any adverse impact on small and micro businesses and rural communities while accomplishing the proposal's objectives:

(1) Not proposing the changes. DWC considered not proposing the changes but rejected that option. Doctors participating in the workers' compensation system have consistently told DWC that the reimbursement rates are too low and make it difficult or impossible for them to continue to participate. The decrease in the numbers of participating doctors from 2009 - 2023 demonstrates the need to increase reimbursement rates to keep pace with inflation and other economic pressures. This demonstrated experience, combined with DWC's statutory mandate for reasonable fee guidelines, means that not proposing the changes is not a viable option.

(2) Proposing a different requirement for small and micro businesses or rural communities. DWC considered proposing a different requirement for small and micro businesses or rural communities but rejected that option. Given the number of insurance carriers writing workers' compensation policies in Texas that qualify as small businesses based on their premium volume, and the fact that many doctors operate as sole practitioners or in small offices, proposing a different requirement for small and micro businesses or rural communities would mean that the different requirement would likely

be the rule, not the exception. That situation would defeat the purposes of adopting the rule in promoting system health through stability and consistency. In addition, such an exception would create an unlevel playing field, where health care providers performing the same work would be subject to different standards and different fees, which could conceivably drive health care providers out of the system instead of attracting and retaining them.

(3) Exempting small or micro businesses or rural communities from the proposed requirement that could create the adverse impact. DWC considered exempting small or micro businesses or rural communities from all or part of the rules but rejected that option. Like the second option, this would create a situation where the exception would be the rule, and would defeat the purposes of adopting the rule in the first place; and would create an unlevel playing field that could drive health care providers out of the system instead of attracting and retaining them. Exempting insurance carriers and system providers could also adversely impact the care that Labor Code §408.021 guarantees an employee that sustains a compensable injury by decreasing the available health care providers' numbers to such a degree that workers' compensation-specific services are not reasonably available. Such an exemption would also be inconsistent with Labor Code §413.011, which requires the commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. DWC has determined that this proposal does impose a possible cost on regulated persons. However, no additional rule amendments are required under Government Code §2001.0045 because the proposed rule is necessary to implement legislation. The

proposed rule implements Labor Code Chapters 408 and 413, which mandate workers' compensation benefits and medical services and fees, including §§408.004, 408.0041, and 413.011.

GOVERNMENT GROWTH IMPACT STATEMENT. DWC has determined that for each year of the first five years that the proposed amendments are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will not create a new regulation;

- will expand, limit, or repeal an existing regulation;

- will not increase or decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

DWC made these determinations because the changes enhance efficiency and clarity; conform the language to current agency structure, practice, and related rules; and make editorial changes for plain language and agency style. They do not change the people the rule affects. The additional costs the changes impose are necessary to comply with the Labor Code's mandates in Chapters 408 and 413 for health care for injured employees that DWC administer programs for workers' compensation-specific services and that DWC adopt fee guidelines and billing and reimbursement policies that are fair and reasonable, account for economic indicators in health care, and are designed to ensure the quality of medical care and achieve medical cost control.

TAKINGS IMPACT ASSESSMENT. DWC has determined that no private real property interests are affected by this proposal, and this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. DWC will consider any written comments on the proposal that DWC receives no later than 5 p.m., Central time, on January 29, 2024. Send your comments to RuleComments@tdi.texas.gov; or to Texas Department of Insurance, Division of Workers' Compensation, Legal Services, MC-LS, P.O. Box 12050, Austin, TX 78711-2050.

DWC will also consider written and oral comments on the proposal at a public hearing at 11 a.m., Central time, on January 23, 2024. The hearing will take place remotely. DWC will publish details of how to view and participate in the hearing on the agency website at www.tdi.texas.gov//alert/event/index.html.

SUBCHAPTER C. MEDICAL FEE GUIDELINES
REPEAL OF 28 TAC §§134.235, 134.239, AND 134.240

STATUTORY AUTHORITY. DWC proposes the repeal of §§134.235, 134.239, and 134.240 under Labor Code Chapter 408; Chapter 413, Subchapter B; and §§402.00111, 402.00116, and 402.061.

Labor Code Chapter 408 governs workers' compensation benefits. It entitles an injured employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. It requires a variety of workers'

compensation-specific services, including required medical examinations; designated doctor examinations; MMI evaluations and IR examinations; and return-to-work and evaluation of medical care examinations.

Labor Code Chapter 413, Subchapter B, Medical Services and Fees, requires in part that the commissioner of workers' compensation adopt health care reimbursement policies and guidelines, develop one or more conversion factors or other payment adjustment factors, and provide for reasonable fees for the evaluation and management of care. Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Medical policies and guidelines must be designed to ensure the quality of medical care and to achieve effective medical cost control; designed to enhance a timely and appropriate return to work; and consistent with §§413.013, 413.020, 413.052, and 413.053.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

CROSS-REFERENCE TO STATUTE. Repealing §§134.235, 134.239, and 134.240 implements Labor Code Chapters 408 and 413.

TEXT.

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

§134.239. Billing for Work Status Reports.

§134.240. Designated Doctor Examinations.

SUBCHAPTER C. MEDICAL FEE GUIDELINES
28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, 134.260

STATUTORY AUTHORITY. DWC proposes amended §§134.209, 134.210, and 134.250; and new §§134.235, 134.239, 134.240, and 134.260 under Labor Code §§408.004, 408.0041, 408.021, 408.023, 408.0251, 408.0252, 408.1225, 413.007, 413.011, 413.012, 413.015, 413.0511, 413.053, 402.00111, 402.00116, and 402.061.

Labor Code §408.004 provides that the commissioner may require an employee to submit to medical examinations to resolve any question about the appropriateness of the health care the employee receives, or at the request of the insurance carrier after the insurance carrier has tried and failed to get the employee's permission and concurrence for the examination. It also requires the insurance carrier to pay for those examinations, as well as the reasonable expenses incident to the employee in submitting to them.

Labor Code §408.0041 provides that, at the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work; or other similar issues.

Labor Code §408.021 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally

resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

Labor Code §408.023 requires in part that the commissioner by rule establish reasonable requirements for doctors, and health care providers financially related to those doctors, regarding training, IR testing, and disclosure of financial interests; and for monitoring of those doctors and health care providers. It also requires a doctor, including a doctor who contracts with a workers' compensation health care network, to comply with the IR training and testing requirements in the rule if the doctor intends to provide MMI certifications or assign IRs.

Labor Code §408.0251 requires the commissioner of workers' compensation, in cooperation with the commissioner of insurance, to adopt rules about the electronic submission and processing of medical bills by health care providers to insurance carriers and establish exceptions. It also requires insurance carriers to accept electronically submitted medical bills in accordance with the rules, and it allows the commissioner of workers' compensation to adopt rules about the electronic payment of medical bills by insurance carriers to health care providers.

Labor Code §408.0252 provides that the commissioner of workers' compensation may, by rule, identify areas of this state in which access to health care providers is less available, and adopt appropriate standards, guidelines, and rules about the delivery of health care in those areas.

Labor Code §408.1225 requires the commissioner of workers' compensation to develop a process for certifying designated doctors, which requires DWC to evaluate designated doctors' educational experience, previous training, and demonstrated ability to perform the specific designated doctor duties in §408.0041. It also requires standard training and testing for designated doctors.

Labor Code §413.007 requires DWC to maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used by the commissioner in adopting the medical policies and fee guidelines, and by DWC in administering the medical policies, fee guidelines, or rules. The database must contain information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols, and must be able to be used in a meaningful way to allow DWC to control medical costs.

Labor Code §413.011 requires the commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as needed to meet occupational injury requirements. It requires the commissioner to adopt the most current methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable payment policies relating to coding, billing, and reporting; and allows the commissioner to modify documentation requirements as needed to meet the requirements of §413.053. It also requires the commissioner, in determining the appropriate fees, to develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of §413.011(d); and requires the commissioner to provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commissioner rules. The commissioner may not adopt the Medicare fee schedule or conversion factors or other payment adjustment factors based solely on those factors as developed by the federal CMS. Fee guidelines must be fair and reasonable, and designed to ensure the quality of medical care and achieve medical cost control. They may not provide for payment of a fee that exceeds the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone

acting on that individual's behalf. When establishing the fee guidelines, §413.011 requires the commissioner to consider the increased security of payment that Subtitle A, Title 5, Labor Code affords. It allows network contracts under Insurance Code §1305.006. It specifically authorizes the commissioner and the commissioner of insurance to adopt rules as necessary to implement §413.011.

Labor Code §413.012 requires the medical policies and fee guidelines to be reviewed and revised at least every two years to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision is conducted.

Labor Code §413.015 requires insurance carriers to pay appropriate charges for medical services under Subtitle A, Title 5, Labor Code, and requires the commissioner by rule to review and audit those payments to ensure compliance with the adopted medical policies and fee guidelines. The insurance carrier must pay the expenses of the review and audit.

Labor Code §413.0511 requires DWC to employ or contract with a medical advisor. The medical advisor must be a doctor, as defined in §401.011. The medical advisor's duties include making recommendations about the adoption of rules and policies to: develop, maintain, and review guidelines as provided by §413.011, including rules about IRs; reviewing compliance with those guidelines; regulating or performing other acts related to medical benefits as required by the commissioner; and determining minimal modifications to the reimbursement methodology and model used by the Medicare system as needed to meet occupational injury requirements.

Labor Code §413.053 requires the commissioner by rule to establish standards of reporting and billing governing both form and content.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

CROSS-REFERENCE TO STATUTE. Sections 134.209, 134.210, 134.235, 134.239, 134.240, 134.250, and 134.260 implement Labor Code §§408.004, 408.0041 and 413.011, amended and enacted by House Bill 2600, 77th Legislature, Regular Session (2001), and last amended in 2007, 2023, and 2007, respectively.

TEXT.

§134.209. Applicability.

(a) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 [~~134.250~~] of this title apply to workers' compensation specific codes, services, and programs provided in the Texas workers' compensation system, other than:

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

(2) prescription drugs or medicine;

(3) dental services;

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

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

(b) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, [~~and~~] 134.250, and 134.260 of this title apply to workers' compensation specific codes, services, and programs provided on or after June 1, 2024 [~~September 1, 2016~~].

(c) If a court of competent jurisdiction holds that any provision of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 [~~134.250~~] of this title or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications that can be given effect without the invalid provision or application and the provisions of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 [~~134.250~~] of this title are severable.

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

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

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

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

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

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

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

(4) Fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be:

(A) adjusted once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024.

(B) adjusted annually by applying the MEI percentage adjustment factor identified in §134.203(c)(2).

(C) rounded to whole dollars by dropping amounts under 50 cents and increasing amounts from 50 to 99 cents to the next dollar. For example, $1.39 becomes $1 and $2.50 becomes $3.

(D) effective on January 1 of each new calendar year.

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

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

(1) MAR amount;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§134.235. Required Medical Examinations.

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

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

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

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

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

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

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

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

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

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

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

(3) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4).

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

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

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

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

(i) Non-musculoskeletal body areas are:

(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 $192 adjusted per §134.210(b)(4).

(C) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the RME 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 RME doctor outlined in subsection (c) of this section.

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

(1) Extent of injury. The reimbursement rate for determining the extent of the injured employee's compensable injury is $642 adjusted per §134.210(b)(4).

(2) Disability. The reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is $642 adjusted per §134.210(b)(4).

(3) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is $642 adjusted per §134.210(b)(4).

(4) Other similar issues. The reimbursement rate for determining other similar issues is $642 adjusted per §134.210(b)(4).

(5) Appropriateness of health care. The reimbursement rate for appropriateness of health care as defined in §126.6 (concerning Required Medical Examination) and Labor Code §408.004 is $642 adjusted per §134.210(b)(4).

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

§134.239. Billing for Work Status Reports.

Work status reports described by §129.5 of this title may not be billed or reimbursed separately when completed as a component of an ordered examination.

§134.240. Designated Doctor Examinations

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

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

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

(A) the injured employee does not attend a scheduled appointment; and

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

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

(3) Reimbursement for a missed appointment is $100 adjusted per §134.210(b)(4).

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

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

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

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

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

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

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

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

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

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

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

(3) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W5."

(4) IR. For IR examinations, the designated doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. The designated doctor must apply the additional modifier "W5." Indicate the number of body areas rated in the units column of the billing form.

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

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

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

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

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

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

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(iv) The test or tests required by Chapter 127 of this title for the assignment of IR, as outlined in the AMA Guides, must be billed using the appropriate CPT code or codes and reimbursed under the applicable division fee guideline in addition to the fees outlined in subsection (b) and (d)(1) - (3) of this section.

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

(D) When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor must bill for the number of body areas rated, and the insurance carrier must reimburse, $64 adjusted per §134.210(b)(4) for each additional IR calculation.

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

(5) Extent of injury. The reimbursement rate for determining the extent of the employee's compensable injury is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W6."

(6) Disability. The reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W7."

(7) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W8."

(8) Other similar issues. The reimbursement rate for determining other similar issues is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W9" when examining issues similar to those described in subsection (d)(1) - (6).

(e) Required testing or evaluation under §127.10 of this title must be billed using the appropriate CPT codes. Reimbursement will be according to §134.203 or other applicable division fee guideline in addition to the examination fee. If a designated doctor refers an injured employee for additional testing or evaluation under §127.10 of this title:

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

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

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

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

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

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

(3) attaching the required documentation.

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

(1) The designated doctor must add modifier "25" to the appropriate examination code.

(2) The designated doctor must add modifier "25" once per bill when addressing issues on the same day, regardless of the number of diagnoses or the number of issues the division ordered the designated doctor to examine.

(3) The designated doctor must bill, and the insurance carrier must reimburse, $300 adjusted per §134.210(b)(4) in addition to the examination fee.

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

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

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

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

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

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

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

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

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

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

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

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

(4) If the treating doctor is not authorized to assign an IR, the treating doctor may refer the injured employee to an authorized doctor for the examination and certification of MMI and IR. The referred doctor must bill under §134.260 of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) MMI. MMI evaluations must be reimbursed based on the applicable established patient office visit level associated with the examination under §134.203 of this chapter.

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

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

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

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4)

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

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

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

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

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

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

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

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

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

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

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

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

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4)

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

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

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

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

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

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

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

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

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

(e) [~~(6)~~] The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Labor Code and Chapter 130 of this title. The treating doctor must [~~shall~~] bill using CPT code 99455 with modifier "VR" to indicate a review of the report only, and the insurance carrier must reimburse $64 adjusted per §134.210(b)(4) [~~shall be reimbursed $50~~].

§134.260. Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Referred Doctors

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

(1) the examination;

(2) consultation with the injured employee;

(3) review of the records and films;

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

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

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

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

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

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

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

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

(2) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4).

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

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

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

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

(i) Non-musculoskeletal body areas are:

(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 $192 adjusted per §134.210(b)(4).

(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 referred 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 referred doctor outlined in subsection (c) of this section.

CERTIFICATION. The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Issued in Austin, Texas, on December 15, 2023.

Kara Mace
General Counsel
TDI, Division of Workers' Compensation