



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation

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Medical Fee Guidelines Frequently Asked Questions

1. What are the current conversion factors applicable under the Medical Fee Guidelines for Professional Services and Workers' Compensation Specific Services (MFG)?

28 TAC §§134.203 and 134.209 through 134.250 are the applicable rules. Beginning each calendar year, the conversion factors are adjusted for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery. *Note: Each year the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) posts a Commissioner's Bulletin on its website announcing conversion factor changes. Bulletins are available on the TDI website at <http://www.tdi.texas.gov/bulletins/>.*

TDI also posts on its website a conversion factor spreadsheet representing each applicable calendar year's conversion factors under the MFG. Conversion factors for calendar year 2018 are provided in Table 1.

Table 1 – Conversion Factors for Services Provided

Category	CY 2018
Anesthesia	\$58.31
Evaluation & Management	\$58.31
General Medicine	\$58.31
Pathology	\$58.31
Physical Medicine & Rehabilitation	\$58.31
Radiology	\$58.31
Surgery in an office setting	\$58.31
Surgery in a facility setting	\$73.19

2. Can the maximum allowable reimbursement (MAR) amount be determined without having the percentage of Medicare's reimbursement under these MFG rules?

The Centers for Medicare and Medicaid Services (CMS) [www.cms.gov] provides free Medicare reimbursement information. These basic steps are used to calculate the 2018 MAR amount, and much of the information in these steps is available on the CMS website.

Step 1. (A) – Multiply the work value by the geographic practice cost index (GPCI)
work value = geographically adjusted work value.

$$(\text{Work} \times \text{GPCI})$$

Step 2. (B) – First determine the location of the procedure. Then, multiply the appropriate practice* expense (PE) by the GPCI PE = geographically adjusted PE value.

$$(PE \times GPCI PE)$$

Step 3. (C) – Multiply the malpractice expense (MP) by the GPCI MP = geographically adjusted MP value.

$$(MP \times GPCI MP)$$

Step 4. (D) – Add the three geographically adjusted values (A) + (B) + (C) = total RVUs.

$$(\text{Work} \times GPCI) + (PE \times GPCI PE) + (MP \times GPCI MP) = RVUs$$

Step 5. MAR – Multiply the total RVU (D) by the TDI-DWC Conversion Factor (\$58.31 or \$73.19 for surgery when performed in a facility setting).

$$RVUs \times \$58.31 \text{ or } \$73.19 = MAR$$

*Note: *In calendar years where CMS uses transitional RVUs, use the transitional rates to calculate MAR.*

3. When are the Medicare Economic Index (MEI) change and the DWC conversion factor announced?

As part of 28 TAC §134.203(c)(2), DWC adopted a provision that will automatically update the conversion factors each year based on the MEI. The MEI annual percentage adjustment is published each November in the *Federal Register* as a part of the Medicare Physician Fee Schedule update. DWC monitors the annual percentage adjustment change to the MEI, and posts the conversion factors for the subsequent year on its website in December.

[\[http://www.tdi.texas.gov/bulletins/2017/b-0041-17.html\]](http://www.tdi.texas.gov/bulletins/2017/b-0041-17.html)

4. Do the revised rules apply to Certified Workers' Compensation Health Care Networks?

28 TAC §134.1 specifies that medical reimbursements for health care services provided to injured employees subject to a workers' compensation health care network established under Texas Insurance Code Chapter 1305 be made in accordance with the provisions of that Chapter. There are two exceptions:

- (A) Required medical examinations under Texas Labor Code §408.004, and designated doctor examinations under Texas Labor Code §408.0041 and §408.151 shall be reimbursed in accordance with 28 TAC §§134.235, 134.240, and 134.250; and
- (B) Treating doctor examinations to define compensable injury under Texas Labor Code §408.0042 shall be reimbursed in accordance with 28 TAC §126.14.

Texas Insurance Code §1305.006 and §1305.153 provide that the following types of out-of-network health care are reimbursed under DWC medical fee guidelines; emergency care, health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract, and health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Texas Insurance Code §1305.103.

5. Can a health care provider be reimbursed for both the Health Professional Shortage Area (HPSA) and workers' compensation underserved area incentive payments?

No. One of the criteria for designation as a workers' compensation underserved area is that the ZIP Code can't be in a HPSA. Workers' compensation underserved areas and HPSAs are designed to be mutually exclusive; however, if CMS adds new HPSAs that duplicate a workers' compensation underserved area ZIP Code, the health care provider may only be paid according to the HPSA allowance, not the allowance for workers' compensation underserved areas.

6. Does a health care provider have to use a modifier to indicate that medical service was provided in a workers' compensation underserved area?

No. Worker's compensation incentive payments are paid based on the ZIP Code where the medical service is provided (Block 32 on the CMS-1500 form).

7. Can health care providers other than doctors receive a workers' compensation underserved area incentive payment?

Yes, workers' compensation underserved area incentive payments are paid to all health care providers when billing for medical services. Note: These rules indicate that the workers' compensation underserved area incentive payment is not applicable:

- when there is a negotiated or contracted amount; and for
- home health services;
- return to work rehabilitation programs;
- work status reports; and
- treating doctor examinations to define the compensable injury.

8. What codes are used for treating doctor case management services and how are these services billed?

In 28 TAC §134.220, DWC set the case management fees for treating doctors using 2007 AMA CPT Codes and descriptors to ensure uniform reimbursement.

9. How will I get reimbursed if I provide a treatment plan to an insurance carrier, but I am not the treating doctor?

The treating doctor is responsible for coordinating the payments, according to DWC's Chapter 137 Disability Management Rules. Health care providers should coordinate with the treating doctor to create a treatment plan in order to receive the reimbursement allowed by 28 TAC §134.220.

10. Are the durable medical equipment (DME) fees also increased based on the MEI annual percentage changes?

No. The maximum allowable reimbursement amounts for DME are specified in 28 TAC §134.203(d). DWC adopts updates to the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule as they occur.

11. What is the MAR for Designated Doctor Examinations for MMI/IR?

The basic billing and reimbursement provisions for the determining Maximum Medical Improvement and evaluation of Permanent Impairment (MMI/IR) in the MFG rules, and billing and reimbursement for MMI/IR are addressed in 28 TAC §134.250 (See *Table 2*)

Table 2 – MMI/IR Examinations Performed by a Designated Doctor

MMI/IR Examinations Performed by a Designated Doctor	Rule for Billing & Reimbursement	Modifier	Reimbursement
Attainment of maximum medical improvement	134.250	W5	\$350
Impairment caused by the compensable injury	134.250	W5	First body area \$300 (ROM) or \$150 (DRE) \$150 per additional body area(s) (ROM or DRE)
Multiple impairment ratings	134.250	MI	\$50 per additional area

12. How does a designated doctor bill for and receive reimbursement for MMI/IR examinations when combined with other DWC ordered designated doctor examinations?

28 TAC §134.240 describes all six examinations performed by designated doctors, but directs the reimbursement for MMI/IR examinations to 28 TAC §134.250, and excludes reimbursement for MMI/IR from the tiered reimbursement structure of paragraph (2) for multiple examinations performed by the designated doctor. MMI/IR examinations performed by designated doctors do not result in the tiering of the non-MMI/IR examinations.

When conducting examinations for issues other than MMI/IR, apply the tiered reimbursement method described in 28 TAC §134.240 to the remaining four examinations. Reimbursement for one of these examinations is \$500. When conducting more than one of these examinations under the same request, the first examination is reimbursed at 100% of the fee for the examination, or \$500; the second examination is reimbursed at 50% of the fee for the examination, or \$250; and the subsequent examinations are reimbursed at 25% of the fee for the examination, or \$125 (*See Table 3*).

A DWC order to a designated doctor to conduct one or more of these four examinations, plus an MMI/IR examination, requires the designated doctor to be reimbursed by all provisions of 28 TAC §§134.235, 134.240, and 134.250. Tables 2 and 3 illustrate these reimbursement methodologies.

Table 3 – Examinations other than MMI/IR Performed by a Designated Doctor

Examinations Other Than MMI/IR Performed by a Designated Doctor	Rules for Billing & Reimbursement	Modifier	Reimbursement
Extent of the employee's compensable injury	134.235 and 134.240	W6-RE	\$500

Examinations Other Than MMI/IR Performed by a Designated Doctor	Rules for Billing & Reimbursement	Modifier	Reimbursement
Whether the injured employee's disability is a direct result of the work-related injury	134.235 and 134.240	W7-RE	\$500
Employee's ability to return to work	134.235 and 134.240	W8-RE	\$500
Issues similar to those described above	134.235 and 134.240	W9-RE	\$500
Multiple examinations under the same specific TDI-DWC order are performed concurrently (other than MMI/IR)	134.235 and 134.240	N/A	1st = 100% of fee 2nd = 50% of fee subsequent = 25% of fee

13. How does a Required Medical Examination (RME) doctor bill and receive examination reimbursements?

RME doctors are reimbursed essentially in the same manner as designated doctors, in accordance with 28 TAC §134.235 and §134.250. The only difference is that the RME doctor does not use the designated doctor modifiers "W5 – W9." The RME doctor should use the appropriate referenced modifiers. Also, the RME doctor is only reimbursed if DWC determines that the examination is in accordance with 28 TAC §126.6(a).

14. What is the Texas workers' compensation system's payment of the technical component cap in certain radiological procedures?

28 TAC §134.203 does not individually adopt specific Medicare billing and reimbursement policies. Rather, the rule states that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, with any additions or exceptions as stated in 28 TAC §134.203. The one exception for the reimbursement formula is that the conversion factors for application of Texas workers' compensation payment calculations as outlined in subsection (c) of 28 TAC §134.203 should be used.

The CMS [www.cms.gov] Physician's Fee Schedule for Diagnostic Radiology provides direction on Medicare limits on the technical component payment for imaging procedures. The Medicare system limits the technical payments for Diagnostic Radiology services to the lesser of the amount payable under the Medicare Physician Fee Schedule, or the amount payable under the Outpatient Prospective Payment System (OPPS). Medicare provides a separate set of practice expense and malpractice expense relative values based on the OPPS for the Medicare Physician Fee Schedule reimbursement formula.

Example Calculations for Beaumont, Texas. Use CPT Code 77078-TC found on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service->

[Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU18A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending.](http://www.tdi.texas.gov/wc/ebill/index.html)

Non-Facility Settings:

1. CMS Physician Fee Schedule Amount

Work RVU (0.00) x Work GPCI (0.951) = 0.00

+ PE RVU (2.90) x PE GPCI (0.924) = 2.6796

+ MP RVU (0.01) x MP GPCI (0.839) = 0.00839

2.6880

x DWC CF \$58.31

= MAR \$156.7373

2. CMS Physician Fee Schedule Amount with OPSS-based Cap

Work RVU (0.00) x Work GPCI (0.951) = 0.00

+ PE RVU (1.72) x PE GPCI (0.924) = 1.58928

+ MP RVU (0.01) x MP GPCI (0.839) = 0.00839

1.5977

x DWC CF \$58.31 (new 2018 DWC CF)

= MAR \$93.1619

3. Reimbursement for services in the Texas workers' compensation system is the lesser of amount between the calculation in step 1 and step 2, or in this example, \$93.16.

15. What are the requirements for home health services provided to an injured employee?

Home health services must be provided through a licensed home health agency as noted in 28 TAC §134.215. Home health agencies in Texas are licensed by the Texas Department of Aging and Disability Services (DADS) <http://www.dads.state.tx.us>.

16. How are home health services reimbursed?

Home health services are reimbursed at 125% of the published Texas Medicaid Fee Schedule for Home Health Agencies. The Texas Medicaid Fee Schedule is available through the Texas Medicaid and Healthcare Partnership (TMHP) website at <http://www.tmhp.com/Pages/default.aspx>.

17. What billing form is used for home health services?

Home health services should be billed following the instructions contained in 28 TAC §133.10 (Billing Forms/Formats) and 28 TAC §133.500 (Electronic Formats for Electronic Medical Bill Processing). Instructions for completing paper and electronic medical bills can be found on the TDI website at <http://www.tdi.texas.gov/wc/ebill/index.html>.

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